THE NATURE AND EXTENT OF AGGRESSION IN NURSES' CLINICAL SETTINGS

by

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ABSTRACT

The concern raised in recent journal articles, reports and books about the level of aggression within nursing was the impetus for this study. Up until the last couple of decades the literature on aggression among health service institutions was sparse. The few nursing studies that are available on aggression deal with the extent and effect of patient aggression on nurses. But not all aggression is patient initiated. A few recent reports speak of horizontal violence, ie, the idea that staff can be aggressive towards each other. Understanding the extent of occupational aggression for nurses whether patient or colleague initiated is thus an imperative research agenda.

A total of 299 nurses were asked for their views on the extent and nature of aggression at their work. Three main issues were addressed. First nurses' understanding of the term aggression was explored. Second, the nature and extent of aggression from patients and others to nurses and vice versa was determined. Third, causal relationships among variables were sought.

Two contrasting methodologies were employed in the study. First, individual nurses (n = 29) from a variety of work settings were asked about their experiences of aggression in the clinical setting. This was essentially a qualitative study and it raised a number of important insights regarding nurses' understanding of the term aggression and the

extent of the overall problem of aggression vis-a-vis patients, nurses and others. Because of the small sample size, it was felt unwise to extrapolate the findings to other similar contexts. Therefore, a second study was conducted - Phase 2 - in which the views of 270 nurses were canvassed. As well as completing a questionnaire respondents were asked to view a short video of an encounter between two nurses. This enabled cause and effect relationships between hierarchy and blame placement to be determined through a survey-embedded experiment. Additionally, structural equation modelling was used to try an account for why aggression persists.

The main findings can be summarised thus: First, nurses' understanding of the term "aggression" encompasses a range of behaviours and attitudes that can be conceptualized along three dimensions: physical-verbal; active-passive; and direct-indirect. In practical terms, this aggression was played out in such behaviours as rudeness, abusive remarks, undermining each other's ideas, refusing to help when needed and, more rarely, actual physical threat and assault. Much of the aggression can be seen as colleagues' failure to play by the relationship rules of work. Second, the majority of respondents at Phase 1 indicated that aggression from colleagues is a major concern for them. Third, this view was largely confirmed in the lager sample at Phase 2. Taken together, colleagues, doctors, and non-nurse managers come under fire in many different work settings. Fourth, female and male nurses had similar views about the level of colleague aggression towards them. However, following colleague aggression, women were more concerned about aggression from patients' relatives and doctors, men had most

trouble dealing with the aggression from their nurse managers. Fifth, nurses' reactions to aggression can be seen in terms of three main response patterns: a stress response, an anger response, and a reflective response. Sixth, there was support for thinking that aggression among nurses is situated within a culture that subscribes to the notion of a "task/time" imperative. Seventh, there was little support for the view that hierarchy influences blame placement preferences for deciding who should be blamed for an incident. However, the Level-2 nurse attracted more blame than either the Level-1 or the Level-3 grade for reacting aggressively towards a colleague who was late. It would appear that the Level-2 grade of nurse has a credibility gap vis-a-vis fellow colleagues. Eight, there was tentative support for the notion that aggression, once begun, may be self perpetuating. Ninth, overall, the results point to a worrying level of nurse-on-nurse aggression in the clinical setting.

DECLARATION

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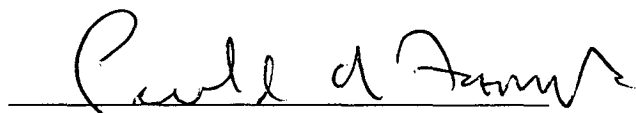

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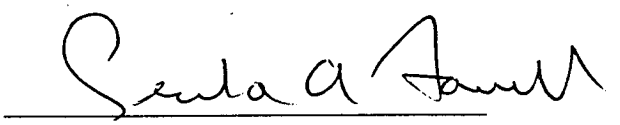

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CHAPTER ONE

INTRODUCTION

1.1 The problem

A cursory thumb through the contents of current nursing journals is likely to hit on an article about aggression. Invariably, this will focus on the extent of patient aggression towards nurses or on the management of these patients. For the present, aggression is defined as the "infliction of harm or threat of harm or injury, either physical or psychological, upon another" (Farrell and Gray, 1992: 2). Yet a moment's reflection suggests that it would be naive to think that patients are the only source of aggression in nurses' workplaces. Nursing is a demanding job and nurses might be expected to get angry or even aggressive towards patients or colleagues from time to time.

While the literature on human service organisations has reported studies from the perspective of interpersonal relations, studies on cohesion amongst workers of "lower" ranks in the organisation have barely been addressed. The lack of attention to intra-staff difficulties among one of the largest groups of human service workers, nurses, is, perhaps, surprising given the complexities of human service organisations, such as hospitals (Hasenfeld and English, 1974; Hasenfeld, 1992). Workers in these organizations are distinguished by the fact that they generally work with or on people, not inanimate objects. Having people as "raw material" has the potential for the development of problematic relationships

between worker and client and between worker and worker. Working with or "on" people is inherently a moral activity - deciding who gets what care is rarely a neutral activity based entirely on clients' needs (Hasenfeld, 1992: 5). Moreover, the formal organisation of human services often entails a wall of bureaucratic impediments that can frustrate both service users' attempts to secure appropriate services and workers' attempts to provide quality care for clients. As well as bureaucratic impediments, personal rivalry and differing ideological orientations among and within professional groups can militate against the achievement of organisational consensus. Roles and responsibilities among the various health care professions often become blurred. In consequence, jockeying for professional status among health care providers within the organisation is commonplace. Within professional groups a concern over status can lead to instances of aggression among members belonging to the same discipline too. For instance, the pre-occupation with professional status among the so-called semi-professions, such as nursing and social work, has led to the phenomenon of "over-professionalization". This can lead to social distancing between these disciplines and their clients and a desire to delegate "dirty work" (ie, daily transactions with clients) to subordinates (Hasenfeld and English, (1974: 21). Not surprising therefore, conflict either between worker and client or between worker and worker might be expected in such organisations. However, the literature on conflict and aggression within nursing has almost exclusively concentrated on examining the extent of client aggression towards nurses. It is assumed that aggression in nursing is one-way traffic, ie, from patients to staff. The fact that staff may be aggressive to patients or towards each other

or that there may be conflict between nurses and other professional groups has rarely been examined in empirical studies.

1.2 The nursing context: background factors

Nursing, like other human service professions has undergone considerable change over the decades. The general public's expectation of nurses has altered (Cherniss, 1995: 6). Nurses are expected to "give" more. In the past it was enough for a nurse to be "responsible, orderly, tidy, neat, prudent, industrious, disciplined, and sensible". Today, nurses are expected to be "empathetic, giving, and in tune with the emotional lives of their patients" (Gow, 1982 cited in Cherniss, 1995:5).

It is worth considering that initial training courses do not produce "finished products" (Cherniss, 1995: 7). Curiously perhaps, while this is recognised by many nurses there are few formal post-graduate requirements for career advancement once initial qualification is obtained. The upsurge in hospital nurses pursuing nursing degrees does not detract from this view. These degrees may be a passport for future promotion for some, however for most they remain generalist qualifications and are not linked to any particular speciality within nursing. In general, nurses are left to "pick up" the necessary specialist skills and attitudes along the way. The evidence for the utility of "sitting beside grandma" suggests that it is not a very efficient way to learn new skills in a rapidly changing technical environment; also the degree to which effective interpersonal skills are learnt is hit and miss. A major public gripe centers on human service workers' poor interpersonal skills.

MacLeod Clark (1985) indicates that nurses use tactics that discourage communication rather than skills that encourage it. Studies reported in Cherniss (1995: 4) provide support for this view. Truax et al. (1974) found that registered nurses scored lower than ten other groups on their ability to communicate empathy. In a study by LaMonica et al. (1976) nurses on the average fell at the mid-point between "hurting another person" and "only partially responding to superficially expressed feelings"(p. 450). It is only in recent years that the need for more explicit education and training in communication skills has been recognised (Dickson et al., 1989: 6).

Coupled with the above is the recent introduction to nursing of private sector business imperatives. While many nurses may subscribe to the values of caring, the settings in which many nurses work value efficiency and technical care (Johnson, 1994: 647). Public sector organizations are now being asked to adopt policies and practices more in keeping with private sector companies. Financial accountability and cost containment are now as much the dominant thinking of nurse managers as are concerns about patient care. More cynically, this is sometimes referred to as the spectre of managerialism (Rees, 1995). With the rise in managerialism has come the notion of doing more with less, of becoming lean and efficient and taking the "tough" decisions. In a culture of economic rationalism, patients are referred to as customers and downsizing becomes a euphemism for lay-offs. Not surprising perhaps in such circumstances staff may fear for their future work. Control of employees and intolerance of criticism is a dominant feature of managerialism according to Rees (1995: 198). During data collection for

the present study, some colleagues said they feared giving their opinions or speaking out on issues in case they may be seen as critical of management and thus jeopardizing their job or future career prospects. Rees suggests that a consequence of policies that emphasise the values of the commercial marketplace as a suitable panacea for public sector organizations leads to a heightened potential for bullying at work and that such behaviour is fostered when workers have been socialised into expecting abusive conduct from their leaders.

Handy (1976 in Cooper, 1987) notes organizations' reluctance to factor in personnel as a capital asset,

> Salaries and benefits are really regarded as maintenance expenses - something to be kept as low as possible as long as the machine does not break down. There is no capital cost and therefore no need for depreciation. Indeed the return on investment in most companies would look very strange if their human assets were capitalized at, say, ten times their annual maintenance costs, and depreciated over 20 years (p.185).

Cooper (1987) suggests that if managers were to focus on the financial costs of their employees "it might be possible to pursue more flexible, imaginative, and futuristic personnel policies. At present corporation planners can choose not to concern themselves with the fickle piece of human "machinery", discounting it or depreciating it at will" (p.185).

Finally, in the context of the local situation, there is an increasing concern felt by many nurses about upgrading their hospital qualifications to a generalist degree. Many feel this imperative is being foisted upon them too hastily and without proper resourcing. Workers on contract worry that they will not be re-employed unless they have non-specific tertiary qualifications or are studying towards meeting the new requirements.

It is with the above backdrop in mind that an examination of staff relations and institutional aggression needs to be situated.

1.3 Significance of the study

a) Institutional aggression in nursing

The data on institutional aggression hardly existed before the 1980s (Lanza, 1983). A literature review with reference to acts of violence by psychiatric patients from 1889 to 1970 extended to only two pages (Ekblom, 1970 in Wondrak, 1989: 2). However, it is now clear that patient "initiated" aggression in nursing as in other health service settings is an important factor in nurses' working lives. Target areas for study have included accident and emergency departments, psychiatric hospitals and community settings. A major survey by the Health Services Advisory Committee (HSAC, 1987) in the U.K. found that nurses working in the psychiatric and accident and emergency departments were most likely to be the recipients of aggression. Three thousand staff, including nurses, doctors, ambulance staff, cleaners,

porters, laundry and catering staff replied to the survey questionnaire, representing a 60 percent response rate. Findings indicated that one in 200 workers suffered a major injury requiring medical assistance in the previous year. For the same period, 11 percent suffered minor injury, 4.6 percent were threatened with a weapon and 17.5 percent were verbally abused. In Australia, Holden (1985), found that nurses reported much higher levels of aggression than workers in the HSAC survey. Holden obtained nearly a 52 percent response rate following a survey of 600 general nurses in hospital and community health agencies. Forty-three percent of respondents reported that they had been "aggressed" against one to four times in the previous 12 months. These findings, along with the many other smaller-scale reports (eg, Fottrell et al., 1978; Fottrell, 1980; Drinkwater, 1982; Cox, 1987; Lawson, 1992), provide a major source of evidence on the extent of the problem both for nurses and other health care workers.

However, a major problem handicapping comparisons between studies is lack of a uniform definition of what is meant by aggression. For example, while both the HSAC and Holden studies seem to be referring to the same class of phenomena the HSAC report refers to them as "violence" whereas Holden uses the term "aggression", and each use different definitional categories in an attempt to group individual incidents. Violence incidents in the HSAC report were classified as those: "requiring medical assistance (major injury); requiring only first aid (minor injury); involving threat with a weapon; and involving verbal abuse". Holden defined aggression as: verbal abuse; physical assault; physical assault causing bodily harm; aggression against property; and

sexual harassment. Curiously, nurses' views have not been sought on their understanding of aggression, nevertheless such studies have spawned prolific rhetoric regarding what needs to be done to combat the perceived threat of a rising tide of aggression from patients.

There is an increasing amount of literature on how to protect oneself when confronted with aggression from clients and the actions to take to ensure aggression doesn't arise in the first place (Wondrak, 1989; Arthur et al., 1992; Farrell and Gray, 1992; Holland et al., 1992; Paterson et al., 1992; Collins, 1994; Wrigley, 1995). In essence, though, an implicit "us and them" mentality underpins many of these approaches. Staff are seen in need of protection from patients who are regarded as potential aggressors (admittedly, for all the "best" reasons, eg, as a result of pain, being in an alien environment, emotionally upset and so on). Sometimes, the language we use may inadvertently help to reinforce this view of patients as aggressors and nurses (and others) as their victims. In a recent workshop on occupational violence, the author was struck by the way the presenter referred to a patient who had been aggressive as a "screamer" and how other demeaning labels had been used to account for clients' aggressive behaviours. Such terminology helps to distance the act of aggression both from the person who is labelled as the aggressor and the person to whom the aggression is directed. These simplistic accounts of the reasons for the occurrence of incidents absolve the influence of health care staff in the genesis of aggression and ignore the bigger picture; as Farrell and Gray (1992: xi) put it, "it would be naive to think that nurses themselves didn't get angry from time to time: looking

after someone can be demanding and stressful". Equally, staff may be aggressive towards each other.

b) Staff-on-staff aggression

The issue of staff-on-staff aggression has rarely been addressed in reports on the incidence of aggression in nursing. An exception is Holden's (1985) study which indicated that nearly 31 percent of respondents reported that their colleagues had verbally abused them. Recently, within the Australian literature the notion of horizontal violence (H.V.) has appeared in nursing discourses on the nature of nurses' work (Roberts, 1983; Street, 1992; Duffy, 1995). In this context H.V. refers to aggression that occurs between nurses themselves whether they are of equal or different grades. But just how concerned are nurses about this aspect of aggression? How does it affect nurses' well-being? Does it occur in all settings? These are just a few of the many questions that can be asked about this aspect of aggression. Industry seems to be waking up to the fact of problematic staff relations and the costs to the organisation of staff conflict (Ryan and Oestreich, 1991). Nursing has yet to grasp this nettle. That this aspect of aggression has hardly been investigated is, perhaps, not too surprising. Aggression amongst employees, like the aggression from patients to staff, has until recently been one of work's "undiscussables" (after Argyris, 1986). Aggression from colleagues is something that for many can be embarrassing to discuss. In general, people want to avoid conflict. Argyris (1986) described a group of highly skilled communicators who, in their effort to avoid conflict and upset, ignored issues that were critical for

organisational problem solving. Their defensive reactions had the effect of preventing the airing of suspicions and mistrust. This resulted in the inhibition of valid information and the creation of a self-sealing pattern of escalating error (Argyris et al., 1985 in Ryan and Oestreich, 1991: 16). In the U.K. it wasn't until the radio programme *An Abuse of Power* (BBC, 1992) was broadcast that the lid on bullying at work was lifted. In nursing, it may be more difficult for staff to admit to staff-on-staff aggression. Presumably, people enter a caring profession because they want to help others, to find that co-workers are abusive may shatter one's expectations about nursing in general and fellow nurses in particular. In order to survive in this situation suppression is one possibility. Suppression occurs when thoughts and emotions are either consciously or unconsciously eliminated from awareness. In this way the individual is protected from overwhelming anxiety or helplessness. Lanza (1983) suggests a similar line of defence when nurses try to come to terms with aggression from patients. Also, staff may become sensitized to working alongside "difficult" colleagues - seeing it as part of the job.

c) The need for further research

A weakness with many studies is their failure to ask nurses for their views. Most studies take the concept as a given and present nurses with pre-packaged definitions of aggression for which responses are sought. There is a need to allow nurses to say what for them are the important issues. For far too long the views of "ordinary" nurses have been ignored. Two main issues are currently outstanding: first, nurses'

understanding of the term aggression, and second the nature and extent of the problem from patients, others and among nurses themselves. Once we have this information we can begin to address another neglected area - explanation for the occurrence of aggression. Thus far, there is little information available concerning the factors that might help explain why aggression occurs or be responsible for its maintenance in nurses' work settings.

As a result of workplace aggression staff have reported a variety of stress-like reactions as well as actual physical harm. For instance, Holden (1985) indicated that a large number of respondents in her study reported a range of negative reactions, including anxiety, anger, fear, helplessness and resentment to both verbal abuse and physical assault. In the HSAC study 1 in 200 workers suffered major injury requiring medical intervention in the previous 12 months. It might be expected that staff-on-staff aggression would produce similar negative outcomes for staff.

Apart from the individual responses the organization may suffer too as a consequence of workplace aggression. Stressed staff may go off sick and the organization may incur financial costs if replacement staff are required. On a more general level, where workplace aggression is high staff morale is likely to be low and patient and staff interactions may suffer as a result thus compounding the situation (Jenkins, 1992).

From the above it can be seen that aggression at work may have important ramifications, for the nurse, the organisation and ultimately the

service we provide for clients. Yet, our knowledge of workplace aggression is limited. It is imperative we have as full an understanding of aggression as possible so that appropriate remedial action can be taken and preventive measures put in place.

1.4 Study overview

Chapter 2 discusses the problems surrounding definitions of aggression and highlights the formidable tasks ahead for researchers wishing to study this phenomenon. The final part of the chapter reviews the literature on aggression within a nursing context. In light of the ambiguity over the concept, the conclusion is drawn that aggression is best understood from the standpoint of what people say it is. The paucity of information regarding nurses' understanding of the term points to the need to ask "ordinary" nurses for their views. Chapters 3 to 5 describe the data collection procedure utilized in Phase 1 of the study. The methods of grounded theory are drawn on for analysis. A detailed account of nurses' understanding of the term aggression and their concerns about aggression at work are presented. Findings indicate that the majority of respondents' concerns focus on nurse-to-nurse aggression. In accounting for why nurses do not pull together more a number of considerations are discussed from the organisational through to the individual perspective. The costs and benefits of aggression are explored and the extent of aggression in nursing is compared to other occupations. Phase 2 was commenced in order to determine to what extent these findings are applicable for a larger sample of nurses. Phase 2 draws on quantitative analyses and Chapter 6 discusses the utility in

combining contrasting research designs within the same study. Some of the major tensions between a scientific/positivistic and postmodernistic perspectives are reviewed in this chapter. Chapter 7 introduces the major areas for investigation during Phase 2 and draws on many of the findings in the qualitative study. In this chapter the design for this phase is presented along with details about the sample's characteristics. Chapter 8 provides a descriptive account of the nature and extent of aggression in nurses' clinical settings. Its findings lend support for accepting the contention that staff-on-staff aggression is a major concern for nurses and that aggression in general (regardless of its source) is a major distress factor for nurses. In accounting for why aggression may persist, Chapter 9 explores the nature of nurses' work in terms of task/time imperatives. Findings lend support for the contention that nurses are wedded to a task/time imperative. Chapter 10 examines the contention that hierarchy rather than the specifics of an incident may be one source of explanation for determining who gets blamed for an encounter between staff. A two-way analysis of variance examines the relationship between variables - grade (Levels 1 to 3) and "blame factor" ("intolerance" and "negligence"). Chapter 11 offers a model whereby once begun aggression tends to increase one's proclivity to aggress and thus help ensure its continuation. This assertion is tested using structural equation modelling. Chapter 12 revisits the major findings from Phases 1 and 2. Their implications for practice are discussed and recommendations are made to ensure best practice policies are created for ensuring safe and conducive working conditions for staff. The final part of this chapter discusses the need for further research.

CHAPTER TWO

THE CONCEPT OF AGGRESSION

2.1 Introduction

This chapter highlights some of the more important current notions regarding the concept of aggression. There are a good many monographs already available on the nature and genesis of aggression - see for instance the books by Tutt (1976), Baron (1977), Owens and Ashcroft (1985), Klama (1988), Archer and Browne (1989), and Goldstein (1994) - but as we shall see there are few texts available that situate aggression within a strictly nursing perspective. The final part of the chapter acknowledges the need for research that offers an understanding of aggression from the perspective of "ordinary" nurses, without which it will be difficult to advance ideas about the true nature and extent of aggression in nurses' clinical settings. The chapter concludes with an introduction to the study design - Phases 1 and 2 - and provides a short discussion on the utility in combining different research methods in the same study.

2.2 Aggression: an etymological perspective

Records show that the word aggression has Latin and French ancestry (Partridge, 1966). From the Latin word *gradus* (step) arises *aggradation* (noun), whence the Latin compound *aggredi*, to approach or to assail (verb), whence *aggressus* (past participle), which in turn became

aggress with its derivative, *aggressio* and an oblique stem, *aggression* (Early Modern French - 1500-1700). Early Latin meanings saw aggressio as a positive attribute, ie, the ability to achieve aims despite obstacles and resistance - "Behold, I see him now aggress and enter into place" (Cambyses in Jackson, 1954 p,13). However, since the 18th century, or before, aggression has generally been associated with negative connotations. It is difficult to give precise dates. Up until Nathaniel Bailey and Samuel Johnson published their dictionaries in 1721 and 1755 respectively, there were few texts available that provided a comprehensive listing of English words in common use (Concise Oxford Dictionary (COD), 1990: xviii). Johnson (1755), defined aggression thus: "The first act of injury; commencement of a quarrel; commencement of a quarrel by some act of iniquity" - a similar notion to present day usage (see below). He provided the following quotation to illustrate its "current" usage.

> "Fly in nature's face?
> But how, if nature fly in my face first?
> Then nature's the aggressor: let her look to't ".
> (Dryden's Spanish Friar)

Quotations in Johnson's dictionary were restricted to the period 1580 to 1660.

2.3 Definitions of aggression

The current conception of the term is broadly similar to Johnson's definition above. The 1991 edition of the Macquarie Dictionary (MD) defines aggression as: "any offensive action or procedure; an inroad or

an encroachment: an aggression upon one's rights. The practice of making assaults or attacks; offensive action in general, ... making the first attack". Current usage includes the notion of states being aggressive towards each other as in "an aggressive foreign policy or where violations by force are used to gain territory". Popular notions of aggression generally indicate it to be a negative attribute or behaviour. However, in some instances it can be used to describe enterprising and "go ahead" people too - similar to its earlier Latin meaning (see above). Also, it is seen predominantly as a male rather than a female attribute. The following quote from Hudson (1977) illustrates some of these latter uses of the term in popular parlance.

> Modern business is always trying to recruit "aggressive" people, by that it seems to mean men with the urge to get ahead fast, knocking over and treading on anybody else who happens to be in their way. Usually the man himself is expected to be aggressive, but sometimes the objective gets transferred to his aims and we have that very remarkable phenomenon, the aggressive goal. Examples of both uses are: "We seek an ambitious, aggressive graduate as national sales manager" (The Age, 1976), "... ambitious technical contributors who have aggressive career goals (Boston Sunday Globe). For some reason the word is applied only to men. No example so far has come to hand for a company looking for aggressive female staff. Some firms, indeed, make it clear that aggressive women are not acceptable as candidates. An anonymous professional

> money management organisation located in San Francisco, California, for instance, is on record as saying that the woman it requires as an administrative assistant/social secretary must be non-aggressive, supportive (Times 22/81).

Once a word takes on virtuous connotations it can make all sorts of unlikely connections. In a recent article in The Australian newspaper (1996) the new vice chancellor of the University of Sydney, Professor Brown, described himself as an "aggressive romantic". Even inanimate objects are not spared. For instance, aggression can be applied to wine when it is described as "heavy, full-bodied and sometimes harsh" (MD).

Aggression may sometimes be used interchangeably or overlap with other emotive terms, such as, abuse, assault, threat, hostility, and violence. Although violence more usually denotes acts of physical aggression, where great force or vehemence is encountered and for criminal behaviour or acts that are illegitimate from a societal point of view, as in, eg, domestic violence or police violence (Archer and Browne, 1989: 11).

In ordinary language we speak of aggression as both an emotion and an act as well as being a cause for an act; the sentence, "She hit him because she was angry" encapsulates these uses of the term. Here, the emotion is anger, which is seen as an explanation for the aggression. In this example "aggression" is used both as a verb and a noun - aggression is a thing we do and a thing we have (Lewontin et al., 1984).

Most dictionaries in common use also allude to aggression as an emotion - linking it to innate behaviour - as in: "the emotional drive to attack" (MD, 1991); or "hostile or destructive tendency" (COD, 1990). These definitions appear to be derived from the psychoanalytical writings of Freud (Archer and Browne, 1989: 4). Freud, and subsequently other psychologists, emphasised that instinct was a major force in the genesis of aggression. They further proposed the notion of aggression building up within one and needing periodic release. These ideas are discussed below, under "The need to express aggression".

Interestingly, the entry for "aggression" in The Encyclopedia of Psychology (1984) begins with the comment, "Aggression is complex and multiply determined in its causes, difficult to predict, and in many instances hard to control" (Goldstein, 1984: 34), however, nowhere does it offer a definition of the concept! Similarly, no definition is proffered under the entry "aggression" in the International Encyclopedia of the Social Sciences (1968). Instead, both entries take the concept as given and proceed to discuss its causes. The lack of a definition offered, possibly, reflects the fact, as we shall see, that aggression is a difficult concept to define in a scientific sense.

In ordinary speech, Klama (1988: 4), suggests that what many descriptions of aggression have in common, perhaps, is that they impute a general quality of assertiveness; ie, people are seen as aggressive when they pursue their goals and interests vigorously and abrasively against each other in society. While acknowledging that it is vital that words be used properly in any field of academic inquiry, he

acknowledges that "definitions are not either true or false; rather, they are either useful or useless " and that, at the end of the day, words are what people take them to mean, and this is largely due to custom. Within a nursing context (as we shall see), aggression has largely been taken to refer to the technical definitions discussed below, however, "ordinary" nurses' use of the term has hardly been explored.

2.4 Aggression: the scientific perspective

According to Klama (1988), the technical or scientific definition of aggression confines itself to describing individuals as aggressive. Social organisations or groups are excluded from the definition; it is not appropriate to talk of nations or societies as aggressive, but only their members (or representatives). Secondly, the scientific definition includes only those acts that are deemed to cause or threaten to cause physical injury to another. This definition does not account for behaviours that threaten to or cause psychological harm to another. Anecdotal evidence is widespread enough to suggest that most of us have experienced emotional pain following another's threatening or abusive remarks. Also, it is important to make the distinction between accidental and intentional injury. Presumably, an act is aggressive only when one can demonstrate that the person intended to inflict harm on another. Thus, a nurse who in the act of removing sutures causes pain would not be seen as aggressive. Including these aspects into our definition of aggression creates ambiguities, how, eg, are we to infer intent and what is legitimate psychological pain? It is difficulties like these that have to be addressed whenever we label an act as aggressive.

And further, where does passive aggression fit into a definition? A person who refuses to answer questions may be just as annoying, indeed, even more so than someone who displays her/his anger in tantrums. Our behaviours and intentions are tremendously subtle and complex. Klama (1988), notes when comparing animal studies on aggression with studies on humans, that the closer we get to human aggression, the more difficult it is to do justice to the complexity of the behavioural interactions that may be involved. Both the popular and scientific writings on aggression should caution us to be extremely careful about saying anything about the nature(s), cause(s), and function(s) of the interactions we choose to label "aggression" in advance of thorough scientific investigation (p. 6).

As we have discussed, aggression is not always viewed as bad. Aggression may be seen in either positive or negative terms, for instance, a student or a business person may be praised for their aggressive pursuit of their goals, while a child may be reprimanded for being aggressive towards a sibling. Although, in many instances, how we view an act as aggressive is problematic. The person shouting to get the attention of a shop assistant may be seen as aggressive or simply standing up for her or his rights. This difficulty in interpreting acts is also illustrated in politics: an aggressor may be viewed as a hero or a terrorist depending on which side of the political fence one stands. And in football, what may be acceptable on the field of play may be seen as criminal behaviour outside the sporting arena. It is interesting to note that when society condones the use of aggression polite substitutes are used instead, for instance, "police tactics" and "counter response" are

used instead of "police aggression". Similarly, nurses talk of "intervention", "restraint", and "setting boundaries" to describe their aggressive behaviour (Farrell and Gray, 1992: 2). Not only do observers "see" the same act differently but the actors involved in the encounter are also likely to view their parts differently from each other. I may accuse a colleague of being aggressive while she maintains she was simply standing up for her rights.

The issue regarding what is and what is not legitimate aggression is not necessarily related to the extent of force used or damage done. Norman Tutt (1976: 16) gives the example of an unrelated adult who clips a child on the ear in the street could be arrested for assault; yet within some classroom situations this may be regarded as reasonable discipline, although it may be contrary to the country's education act. Aggression is permissible, it seems, in authority relationships, and under certain prescribed contexts, such as sporting contests. When aggression is socially prescribed as a legitimate means of control or punishment Walter (1976 cited in Tutt, 1976: 35) suggests that its aims are made clear and there are limits imposed on how much force, or destruction may be used. An extreme example of this in practice was seen during the Iraq conflict of 1991. It was suggested by the then military USA commander and governments arrayed against the Iraqi president, that it was legitimate to attack military targets but not civilian ones. Of course, cynics might argue that this was mere rhetoric to satisfy a sceptical public and anyway an impossibility given the inevitability of misdirected firing. In any event, many civilians were casualties.

Deciding who is the defender and who the aggressor is not always easy either. Usually we refer to those who make the first attack as the aggressors; when countries go to war we talk of the enemy as the aggressor and we as the defender. Johnson (1990: 19) notes that, while it is quite tempting to view human transactions in simple cause-and-effect terms, the reality of this is more complex. For instance, we tend to blame others for our feelings of anger, particularly if we feel guilty and ashamed about what we have done. Alternatively, if we are the recipient of another's angry reaction, that person believes we are unquestionably the cause of the problem. But of course, it is not always possible to tell if the "first" attack is not itself a response to an earlier provocation; and further, the roles of victim and perpetrator may occur in rapid succession in the same individual. Therefore, caution is called for in identifying the roles of attacker and defender. Similarly, deciding on the veracity behind union/management confrontations is complex.

Aggression is not a fixed entity, each incident is a reflection of an interactional exchange that is different for each situation. Therefore, a slap, a kick, a cuss, are not simply to be seen as varying aspects of the same "thing" (aggression) that can be precisely measured. However, it is reasonable to assume that there will be some instances of aggression where there may be good agreement (prototypical cases) and occasions where there is less agreement (Rosch, 1978), in other words, we have a solid core surrounded by fuzzy edges (Archer and Browne, 1989). Applying this idea to psychological definitions of "aggression", these researchers suggest that one can begin to identify prototypical cases of "aggression" in terms of the features which are relevant for categorising

an act as one of "aggression". Archer (1977) outlines three such features: firstly, there is intent. Subjectively, the person must have intended to harm by injury, ridicule, or by preventing access to a resource. In order to identify one's motivation for a given action judgements have usually to be based on verbal statements, actions, and contextual cues. The second feature includes actions which cause damage or are likely to do so. Included here are actions that cause physical damage as well as behaviours, such as, verbal abuse, staring, and clenched fists which signal intent to harm. Finally, the third feature relevant to categorisation is emotional state. A distinction is made between "hostile" and "instrumental/manipulative" aggression. When the primary goal is to cause harm, suffering or injury to another the aggression is labelled as hostile, whereas instrumental aggression does not have as the primary goal the infliction of harm - the aggressor in this instance uses aggression to obtain other goals. For example, a bank robber may cause suffering to the cashier in his attempt to secure cash. Looked at in this way, the distinction is made between "cold" aggression, that is, the intent and the infliction of harm is not accompanied by the emotional state "anger". In a prototypical case, the emotional state associated with aggression would be present. It is the presence of all three features - intent, injurious behaviour, and emotion - that produce a prototypical case of aggression. And if one or more of these features are absent, or present to a lesser degree, Archer and Brown (1989) suggest there will be more disagreement whether the category "aggression" applies. Presumably, in the above definition a person who wilfully neglects to perform an act and because of which leads to another's harm would be guilty of aggression too. For instance, a manager who fails to

take appropriate action to prevent an employee suffering psychological stress or physical injury would be seen as showing disregard for the employee's mental well-being and physical health. Looked at from this perspective aggression can be seen in acts of commission as well as in acts of omission.

Of course, the more precise our terminology and the more restrictive we are in what we include in our definition the greater the likelihood of establishing a shared understanding. Take the concept "rich". On its own it could mean many things. One person may say it is to have a million dollars, another might argue for 10 million, while a third person may suggest it has nothing to do with money, seeing it to mean having a positive attitude to life. We could have avoided this confusion by stating at the outset what exactly we meant by the term. If we had said to be rich meant having x number of dollars all would know what was intended by the term. Not everyone may have agreed with this definition, but at last there would be little disagreement over what the researcher was looking for. The narrower we confine our definition of the concept the greater confidence we have in documenting its occurrence. However, narrow definitions produce narrow results. If, for example, we confine our definition of aggression to kicking and punching, we lose sight of all the other acts that are indicative of aggression and we would have missed out on describing possible antecedent factors that may have triggered the events. This is not to suggest that one can ever know the totality of the phenomenon under investigation, rather the suggestion here is that we should attempt to include for investigation as many aspects of the phenomenon as is practicable.

In an attempt to examine lay notions of aggression social scientists have asked people to list incidents of aggression that they had witnessed or been a party to. While results from these studies point to the cognitive structures people may use in determining an act as aggressive it should be pointed out that results to date are tentative and that social scientists are still far from agreement as to what is meant by aggression and what are lay typologies of aggression. It is highly unlikely that any one definition of aggression will be transparent enough for all to agree that a given act is aggressive, indeed looking for *the* definition of aggression maybe akin to peeling an onion to find its core.

In order to move away from social scientists' conception of the term "aggression", Steven Muncer et al. (1986) asked 53 undergraduate students to sort real-life instances of aggression into meaningful groups on the basis of perceived similarity. Instances of aggressive scenarios were grouped in terms of verbal-physical forms, stranger versus familiar aggression, and the degree to which the victim of the aggression could defend himself - equity-victimisation dimension. In order to generate examples of "aggressive" incidents for sorting, the authors in this study asked 147 undergraduate students to "list as many personally experienced aggressive episodes as they could". From the list of incidents obtained, content analysis indicated that 24 situations represented the range of responses. This procedure ensured that subjects were not cued by events that the experimenters thought to be important. Overall, the conclusion from this study is that "subjects show considerable consensus in the major dimensions used to categorise routine aggressive incidents". It seems that context (including, paying

attention to pre-fight factors), form (eg, distinguishing between verbal versus physical aggression), and social judgements (eg, determining whether the attack was justified) may be central to subjects' categorical schema. Unfortunately subjects weren't asked to say what dimensions, if any, they had used to categorise events, instead we are left with the researchers' interpretation of the results through cluster analysis and multi-dimensional scaling, which in the best solution accounted for no more than 23% of the variance. The research of Muncer et al. is interesting though in that it suggests a methodology for generating real-life instances of "aggression" where the subjects are not cued to respond in ways previously suggested by theorists (Archer and Brown, 1989).

In most instances, it seems, taxonomies of aggressive behaviour have largely been based upon social scientists' common sense or theoretical notions of the forms of aggression and have received no formal empirical testing (Muncer et al., 1986). In reviewing the literature on formulations of aggression by psychologists, Anne Campbell et al. (1985), suggest that taxonomies of "aggression" are based on motivation and form. Motivational taxonomies include: "hostile versus instrumental (Feshback, 1964; Rule, 1974), normative versus expressive (Wolfgang and Ferracuti, 1967; Berkowitz, 1978), status enhancer versus status defender (Toch, 1969), provoked versus unprovoked (Zillman, 1979), and offensive versus defensive (Zillman, 1979)". In relation to form taxonomies Campbell et al. (1985) include: "direct versus indirect (Buss, 1961), verbal versus physical (Buss, 1961), active versus passive (Buss, 1961), planned versus unplanned (Schott, 1971), fantasy versus reality (Schott, 1971), and self as target versus other as target (Schott, 1971)".

Like Muncer et al., Campbell et al., suggest few of these taxonomies have been shown to be related to everyday occurrences of "aggression" outside the laboratory. It would appear that social scientists are far from agreement on what constitutes "aggression". This is perhaps, not surprising given the comments of Goldstein (1994) below.

What many authors on aggression seem to accept is that every aggressive incident is a "person-environment duet" (Goldstein, 1994: 8). Acts of aggression are the dynamic outcome of the interaction of people and their surroundings (physical and social); "the environment stimulates us and we it - each providing reciprocal influences in an ongoing cycle. In other words, aggressive behaviour is a function of the person and her/his environment, ie, B = f (p,e) after Lewin 1936 cited in Goldstein (1994: 7). "There is give and take, with each part of the system providing reciprocal influences on each other. We shape our environment and in turn are shaped by it in a never-ending cycle of mutual influence" (Goldstein, 1994: 8 on Krupat, 1985: 12). These authors are underlining an interactional perspective of aggression; that to understand any aggressive act one has to acknowledge the transaction that occurs between all the parties. Note, that to contribute to an event's happening does not infer culpability. For example, nurse A is angry and shouts at nurse B, in this instance nurse B would be the innocent party. But it is rather simplistic to view an aggressive incident like a snapshot in time. Perhaps, B because of her features reminds A of a person she intensely dislikes. Although most research has attempted to elucidate the characteristics of the assailant it is important to remember that both parties - the aggressor and victim - each have a part in the resulting

encounter. In the review provided by Rice et al. (1989) on the characteristics of violent individuals and assault victims, there is the suggestion that patients are more aggressive when they are young or have severe emotional or physical distress. In the case of staff who are assaulted, it is suggested that females are less likely to be victims than males. Other characteristic behaviours of staff who are victims of assault include; demanding activity from patients, refusing requests and imposing limits, imposing sanctions, inexperience, and being perceived as weak. There is also the suggestion that people who are themselves prone to angry outbursts have a high proclivity for being involved in aggressive encounters themselves. It seems inability to manage one's own anger leads the individual to behave in ways which enhance hostile interactions with others and this in turn leads to the development of psychological distress (Johnson, 1990: 54). In the field of child abuse, the notion of the child as passive victim is now being questioned. The suggestion is that child abuse grows jointly from "psychological disturbances in parents, abuse eliciting characteristics of children, dysfunctional patterns of family interaction, stress-inducing social forces, and abuse-promoting cultural values" (Belsky, 1978: 17, cited in Goldstein, 1994: 87).

2.5 Aggression, assertion and passivity

As we have seen above, how we decide that a given act is aggressive depends as much on our personal viewpoint as on any inherent characteristics of the act itself. This bias in interpreting acts can sometimes be seen in the choice of words we use to label an act, eg,

assertion or aggression. Unfortunately, these two words are used synonymously by some people. This is not surprising given the dictionary definitions surrounding the words assert, assertion and assertive, including self-assertive. These definitions include such notions as the ability to state clearly one's views and the insistence on one's rights or opinions, including demanding recognition and dogmatism. Included in The Concise Oxford Dictionary (1990) definition of aggression the terms "forcefulness and self-assertiveness" are included. However, textbooks on the nature of assertion, while acknowledging the need to be clear, direct and confident in manner, play down notions of dogmatism. According to Farrell and Gray (1992: 3) "an aggressive manner fails to acknowledge the other's rights, and a passive manner fails to acknowledge one's own rights". Of course, passivity may be used to "assert" one's rights too, as in refusal to co-operate. An example of this is encountered when protesters engage in sit-ins in an attempt to block the actions of others. To help differentiate between aggression, assertion, and passivity Farrell and Gray (1992: 4) propose the following distinctions (Table 2.1):

Table 2.1 **Types of response**

Aggressive	Passive	Assertive
Non-verbal indicators		
Points	Fidgets	Arms and hands relaxed by side
Stares/glares	Looks away or down	Level eye contact
Stiff upright posture	Slumped posture	Confident, upright appearance

Loud voice	Quiet, whining voice	Clear and calm speech of medium tone
Rapid speech	Hesitant speech	Even tone of voice; spaced comments
Verbal indicators		
"Look you"	"Excuse me...sorry..."	"I believe..."
"Do it this way"	"I wonder...do you mind?"	"I'd like us to look at the issues"
"Go on, say your piece'	"Silence"	"I'd like to hear your views"
Swearing	Uses words designed to please or not cause a fuss	Can keep frustrations under control

Leaving aside the difficulties over operationalizing the concept, another avenue of intense investigation has centered around our need to express aggression.

2. 6 The need to express aggression

We can probably say with considerable confidence that the potential for aggression is in everyone. Most of us have had angry feelings and have behaved aggressively at some time in response to another's threat, to relieve tension and frustration, in pursuance of some goal, to save face, to impress, to coerce, to teach someone a lesson, for pleasure or simply to get attention. Aggression therefore, can be said to be a "natural" attribute. In the celebrated book "On Aggression", Konrad Lorenz (1966) stated,

> There is evidence that the first inventors of pebble tools - the African australopithecines - promptly used their

> weapons not only to kill game, but fellow members of their species as well. Peking Man, the Prometheus who learned to preserve fire, used it to roast his brother: beside the traces of the regular use of fire lie the mutilated and roasted bones of Sinanthropus pekinensis himself (cited in Leakey and Lewin, 1977: 208).

Lorenz (1950) along with others, proposed a psychohydraulic model to account for all, so-called, "instinctive" behaviour, including aggression. This model proposes that our instinctual drives can be conceptualised as "forces" that well up inside our brains and are released periodically either as a result of the accumulating internal "pressure" or as a result of triggering mechanism in one's environment. Lorenz, suggested that to maintain human harmony it was important that our aggression be channelled into harmless activities, like competitive sport. This is a similar notion to Freud's (1920) ideas on human aggression.

Freud insisted that aggression is innate and that a failure to express it can bring on physical and mental illness. Aggression for Freud was driven by unconscious forces, although it could be held in check when individuals engaged in "cathartic" behaviours. For Freud, individuals have a death instinct and if it is not turned outwards onto others it will turn inwards onto one self. According to instinct theory, aggression is inevitable and cannot be removed from human existence even when all our needs are satisfied. The best that can be hoped for is that humans can learn to keep it under control. The innate beastliness of our nature is further emphasised by the psychiatrist Anthony Storr, in his book

"Human Aggression", published in 1970. Desmond Morris's (1967) book, "The Naked Ape", also supports the idea of humans as essentially aggressive and in "Manwatching" (1977), another very popular book by Desmond Morris, rape is accounted for as being of a similar behaviour to that seen in other species, ie, it is an extreme form of dominance display (p. 125). These notions are evident today in the press and popular literature. Newspaper headlines are frequently given over to reporting rapes, muggings, violent protests and so forth, and perpetrators of aggressive acts are described as "animals" and "savages". The horrific murder in England of the Liverpudlian toddler, James Bulger, by two Merseyside ten-year olds in 1993, prompted the banner headline, "20 years of hell await the evil angels of Mersey" in The Australian newspaper. The idea that the boys were "freaks of nature" or that the family and society generally were to blame competed with explanations which suggested the innate beastliness in children; as one journalist put it, "Instructing the young to suppress their innate evil impulses is the individual and collective responsibility of adults", and the fictional accounts of the nastiness of children in William Golding's (1958) novel, "The Lord of the Flies" was proffered in support of this contention.

Although these essentially pessimistic views about human nature have been incorporated into popular conventional wisdom, Leakey and Lewin (1977) strongly contest them on three counts. First, they argue that no theory of human aggressive behaviour can be so firmly proved; second, that the evidence proffered in support of the aggression theory is simply not relevant for human behaviour; and third, the clues that do impinge on the basic elements of human behaviour are much more persuasive in

pointing out humans as co-operative rather than as aggressive animals. Klama (1988) suggests that this notion of the beast within, ie, the idea that aggression must be released at intervals is no longer considered relevant given the scientific evidence that is currently available (see below).

The above notion of aggression as an instinct requiring release may be acceptable if it were possible to define clearly just what is meant by the term aggression. How could such a model be tested without a clear definition of aggression (which includes its behavioural manifestation). As we have seen, the concept of aggression is jelly-like - it groups together a wide variety of behaviours that serve many different functions. In an attempt to offer a model of aggressive behaviour that incorporates its complexity as well as the mechanism of its release Klama cites the work of Pribram and Melges (1969). These authors suggest that human aggressive behaviour, though immensely more sophisticated, acts rather like a domestic thermostat which incorporates a negative feedback loop. Once the domestic heating system is turned on and it achieves a set temperature its major function is to maintain the status quo. If the house becomes too warm the thermostat will turn the system off until the temperature returns to the temperature previously set. If the house becomes too cold the system is turned on again until the desired temperature is reached. In humans, the thermostat can be likened to our ability to appraise incoming events/environmental happenings and our resulting actions as attempts to maintain our preferred cognitive and emotional "settings". Of course, what we appraise as threatening in one situation may not be in another. Being delayed on our way home may be

an irritation when we want to get home to watch a live broadcast of a football match with friends, whereas at another time, when on our own, we may welcome the opportunity to delay going home. Also, this model accounts for differences between people with respect to the "same" stimulus. It is accepted that our appraisals are conditioned by past experiences and current circumstances. Looked at from this perspective the study of aggression is a far more subtle and complex issue than the instinct theorists would have us believe. While "lower order" behaviours, such as, the ability of a new born baby to suck, may be related to instinctual determinants, higher order behaviours, for instance, the ability to negotiate for an increase in one's salary, are clearly related to culture. As Farrell and Gray (1992) note, it is in the social environment that collections of genes are turned into people. They draw on the work of Klama, 1988 when they comment:

> It must be recognised that it is possible to win arguments and impositions without recourse to aggression and that negotiation and compromise are just as effective as fighting and swearing. To lose without feeling humiliated or to bear grudges and seek vengeance later are choices that can be made rationally. To say that human beings are "naturally" aggressive - whatever that means - and leave it at that ignores the contribution of the social environment in shaping and guiding people's response. If there is such a thing as a gene for aggression, it does not follow that we cannot influence its consequences for our behaviour (p. 6).

Because the term aggression is so commonly used to describe so many diverse behaviours it is perhaps not surprising that we have come to accept its legitimacy as a natural form of behaviour and to think of it as an instinct. However, the repeated use of a phrase is no grounds for assuming its actuality as instinctual. Without demonstrating that there is a single motivational source for all things that people refer to as aggression, the case for such inference has to remain open (Klama, 1988: 12).

2.7 Aggression in women and men

"Is it possible that only one half of humanity (men) has destructive inclinations, and that the other (women) does not? Are there such things as male and female forms of aggression?" asks Margarete Mitscherlich (1987: ix, 23). The study of sex differences regarding the cause and expression of aggression spans a wide field ranging from insights gained from psychoanalysis to the experiments of biologists.

From a psychoanalytic perspective, men are said to be more likely to deny and repress their feelings than are women. Men find scapegoats and rivals on which they act out their aggression and fantasies of revenge without conscious guilt or anxiety, whereas women tend to exhibit more passive-aggressive and dependent conduct. Psychoanalytical theory posits that men's aggression is bound up with castration anxiety and women's is bound up with penis envy and a deep-rooted fear of loss of love (Freud, 1961: 252).

However, much of the inherent entrenched views of psychoanalysis about the central role of early childhood experiences for women are now being challenged, and feminist writers, who may also subscribe to the notions of repressed drives and infantile fantasies, are urging women to bring into consciousness their aggression and thus create a new self-image in order to break out of set role expectations. A woman's willingness to suffer is encouraged by gender-specific socializations, which has allowed men to be aggressive, self-assertive and to suppress emotions. Psychoanalysis, it is argued, should not lose sight of the influence of society on individual behaviour (Mitscherlich, 1987).

While, from a psychoanalytical perspective, girls may envy boys and their genital equipment, the effect of parents' tradition-bound cultural notions of value ensure that a little girl will at an early stage be encouraged to experience her lack of a penis as proof of her inferiority. Although infantile envy of male genitalia, such as can be seen in little girls is rarely found in later life of women (Horney, 1923); the feelings of inferiority that derive form such envy remain in later life (Mitscherlich, 1987). Men, too, are subject to society's norms and values. It is suggested that it is harder for a man to confront his envy of women (an envy of giving birth and having breasts) in a society that values contempt of women, not openly perhaps, but rather subtly. For instance, while women may represent 50% of the workforce in some countries they may still have to juggle outside work with homework, thereby placing even heavier demands on them. In many countries women are often paid less for work than men even though their work is of a comparable nature to that done by men. Despite an increase in the number of women at work,

women work mainly in salaried occupations in low status vocational or service-related jobs. Nursing, a largely female occupation with connotations of nurture and care might, from a psychoanalytic and feminist perspective, be said to be evidence of the continued existence of a patriarchal order in society.

Leaving aside the controversy over whether we should blame inner or outer forces for shaping aggression in women and men, what empirical evidence is there for such psychoanalytical claims that women turn their aggression inwards onto themselves, whereas men look for scapegoats to vent their aggression on? Are there differences between the sexes in the behavioural manifestations of aggression too? The evidence is equivocal as to whether women differ from men in their experience and expression of anger. In a review by Johnson (1990), little overall difference between men and women regarding the expression and suppression of anger was found.

Views which suggest there are differences indicate that women may be more likely to experience strong feelings of anger and anxiety frequently, as well as report a higher level of fear and anxiety about expressing aggression. Men tend to be more cynical, bitter, and dominant than women. So even if women report experiencing anger and irritation more than men, they are reluctant to openly express their aggression or engage in aggressive behaviours (Johnston, 1990; McCann et al., 1987). In a study by Felson (1986), while females and males were equally likely to engage in verbal attack, women were more likely than men to engage in reproaches. Felson suggests that the findings of this and other

studies lend support for the notion that women prefer to use reproaches as they are a milder type of verbal aggression.

At work, Harburg et al. (1979) found that women were likely to be more reflective than men in dealing with an angry and unjust boss. On a wider front, Fritz (1979) found that when location was examined it became clear that this was an important determination of differences between the sexes. For instance, women are as likely as men to feel anger when provoked in public, however, men are more likely than women to express their anger in this situation. It would seem that men are more likely to react to threats to self-esteem and pride in public than women although studies in the work situation indicate conflicting results.

Frodi et al. (1977) suggest that men and women do not differ from each other with respect to physical aggression. Straus (1980) found that among a USA national sample of families 12 percent of husbands and wives had attacked each other within the past year. In terms of frequency of aggression, in half of these families, both partners attacked each other the same number of times, however the effects of an aggressive attack were worse when men were the attackers. Baron (1977: 221) notes that the disappearance of clear-cut sex differences may signal women's greater emancipation in that they no longer feel constrained to behave as "ladies" and have the confidence and self-esteem to express how they feel.

Studies that suggest large differences between the sexes and those that do not show such findings differ in one crucial aspect, ie, the strength of

the provocation used to measure respondents' resulting aggression. When subjects are exposed to weak provocation men are more aggressive than women, however when strong provocations are used this difference disappears. This pattern of response may indicate that males may have a lower "boiling point" than females (Baron, 1977). Also, men are likely to respond to direct verbal insult more readily than women (Frodi, 1977 cited in Baron, 1977: 219).

Johnson (1990: 143) notes that he is still baffled concerning what causes men and women to aggress. He makes tentative suggestions that perhaps men and women become upset when their self-esteem and self-worth are challenged, however the triggers responsible may be due to the different socialisation process. For instance, men become aggressive when their occupational status and personal career achievements are threatened, women become angry when close relationships are threatened. Another factor thought important in perceived differences among the sexes may lie in women and men's different communication styles. For instance, women tend to disclose more information of a personal and feeling kind to their dating partners; their male partners, on the other hand, prefer to talk about more factual matters, such as, politics, ie, neutral or unemotional information. Also, women may be more sensitive to social and non-verbal cues, be better listeners, and have greater empathy and during interpersonal conflict are more likely to show strong negative emotions, while sending double messages thus compounding communication difficulties (Rubin et al., 1980). Johnson, at the risk of being accused sexist, suggests that because of such behaviour it is difficult "for us guys to know what's going

on". He speculates that these differing communication styles may be the catalyst that influences men and women regarding their different perceptions on the causes of anger.

On a biological perspective, researchers in Norway studied the effects of testosterone on aggressive behaviour. Results indicated that circulating levels of testosterone in the blood have an influence on provoked aggressive behaviour and a readiness to aggress. Studies among prisoners also indicate the influence of testosterone on aggression, however these studies do not preclude the possibility that early childhood experiences are important in determining one's aggressive behaviour in both males and females (Johnston, 1990). For instance, in a report by Fagot et al. (1985) infants' "assertive" behaviours were observed and again when they were toddlers 9-11 months later, no differences were found between the sexes with respect to such assertive acts as hit, push, shove, and grab or take object or try to take object. Nevertheless, teachers were observed to respond differently to each sex. Forty-one percent of the boys' assertive acts were responded to compared to ten percent of the girls' acts of assertion. By the toddler stage boys were found to be more assertive than girls mainly because the level in girls had declined over the period. These authors suggest that during infancy it is harder to interpret the meaning of acts, for instance, is a push meant aggressively or not? Without a yardstick to go on people fall back on stereotyped beliefs and in this case since it is expected that boys will be more aggressive than girls boys' assertive or aggressive behaviour will be responded to more often by adults whilst corresponding behaviour in girls is ignored. Some of this attention will be positive, consequently

boys will learn that such acts can bring about a change in the situation more than girls. Such reinforcement of behaviour ensures its recurrence and the stereotype is reinforced also. Smith (1989 cited in Archer and Brown, 1989: 80) acknowledges that this is not the only interpretation here, nor does it rule out biological implications but it does accord with other findings from other studies of a similar type.

In general, the biological studies on aggression are far from definitive, indeed it might be that aggression is both a consequence and a cause of high testosterone levels (or other hormonal levels) in humans (Owens and Ashcroft, 1985: 31). Both the social and the biological sciences have not yet clarified what the differences are, if indeed there are any, between male and female aspects of aggression.

Thus far, defining an aggressive act, as we have seen, is akin to nailing jelly to a wall. In general terms our original notion of aggression as an assertive act where the person pursues her/his goals and interests vigorously and abrasively against another (Klama, 1988: 4) would seem to suffice so long as we can infer intent, ie, we can say that the aggressor intended to cause the other person either emotional upset or physical harm. This is often a problematic assumption though. We saw that there may be competing claims as to the status of the act depending which side of the conflict divide one is standing on. For instance, a person may feel aggrieved when accused of aggression as a result of, what to her/him, was an overreaction on the part of the aggressee.
Leaving aside the definitional minefield for a moment, attempts to determine the basis for aggression suggest that while we are all capable

of being aggressive it is in one's social environment that one should look for understanding the reason for its occurrence. Finally, attempts to distinguish differences between men and women leave social scientists floundering.

The above incomplete picture should not however deter us from developing descriptions of aggressive acts for given contexts, including nursing. One way out of the definitional minefield might be simply to ask people what for them is aggression, as did Muncer et al. (1986). With this approach, we are accepting aggression as that which people say it is. And by asking a group of "similar" individuals (eg, nurses), we can at least begin to contextualize aggressive incidents for given contexts. Once this is accomplished, we will have the basis for dialogue as to what is seen as aggression within particular situations. John Beynon's (1989) ethnographic study on the use of routine violence in a school is an example of locating aggression within strict confines. Beynon notes that violence was used by both parties (teachers and students) as an important strategic resource in impression management. Stannard-Friel (1981), also provides a graphic account of the routine use of aggression within a particular setting. He describes the aggression meted out by attendants and nurses to patients in a psychiatric institution. This author catalogues the way in which the ward was eventually "taken over" by new recruits who organised and implemented "brutal, sadistic, and humiliating treatment programmes"(p. 14), in the guise of "therapy" for more than three years. Apart from this last cited study, almost all of the studies on aggression in nursing, it seems, have confined themselves to studying patient aggression towards staff. Three main issues: the

incidence of aggression upon staff; its effect on staff; and its management have been the main targets for study. Recently, a fourth issue: the notion of horizontal violence, written from the perspective of oppression theory and feminist critiques on nursing, has emerged in journals. It is consideration of these four aspects of the aggression discourse in nursing that the next section addresses.

2.8 The nursing perspective on aggression

Generally, there is little empirical literature on aggression within a nursing context. Wilson and Kneisl (1992), in their popular book on psychiatric nursing, paraphrase Ryan and Poster (1989) when they comment, "There are relatively little data ... or systematic description of the frequency, types, or consequences of assaults on nursing personnel" (p. 490).

Wilson and Kneisl (1992) confine the main argument of their chapter on aggression to a discussion of client violence only, which they define as: "Psychiatric, client violence is ... behaviour by a psychiatric in-patient that threatens or actually harms or injures persons or destroys property" (p. 490). This is similar to the definition used by the American Psychiatric Association (1987). Most of the nursing literature to date, offers only a cursory description of aggression. The concept itself is usually taken as a given, ie, aggression is aggression or concepts and ideas are borrowed from the social sciences. For instance, a 1992 Australian text by Arthur et al. offers the following as a definition of aggression, "Any

intimidating or threatening behaviour which leads the carer to fear personal injury or to be concerned for the physical safety of the client or others" (p. 80). These authors stress three causes of aggression. Firstly, biological factors are mentioned, such as, a genetic predisposition to develop aggression, and brain lesions. Secondly, psychological factors are discussed, these include Freud's ideas on instinctual drives and the ideas of Dollard et al. (1939) on the role of frustration in aggressive outbursts. Thirdly, factors within the system are briefly discussed in the context of Bandura's (1973) ideas on aggressive behaviour being learnt through observation and direct experience.

2.8.1 The incidence of aggression in nursing

It would appear that nurses are among the most likely targets for patient assault (Fottrell et al., 1978; Fottrell, 1980; HSAC, 1987; Vousden, 1987; Poster and Ryan, 1993). Most of the studies on the incidence of aggression towards nurses have been conducted in psychiatric hospitals and indicate widely varying rates of aggression towards nurses. For instance, in the Fottrell et al. (1978) study, carried out in a large British psychiatric hospital over a nine-month period, these authors conclude that the chances of sustaining a serious physical injury is remote. For a population of 109 patients there were 175 aggressive incidents of which 106 (61%) consisted of abusive and threatening, demanding or disruptive language (about 1.6 incidents per patient on average). On 69 occasions (39%), there was physical violence. Lion et al. (1981) estimated that there were about 1,108 assaults a year in a large state-

run psychiatric hospital in the USA with a population of about 1,500 patients (less than one incident per patient). In contrast, Casseem (1984) reports for a four-month period an incident rate of 152 violent attacks for an in-patient population of 736, or about 456 incidents over a year (about .62 incident per patient).

As well as estimating the number of incidents it is also important to determine the number of incidents that are directed at staff. In the Fottrell et al. study cited above in only 13 percent of incidents was the violence directed towards others. In the Casseem's study, a third of incidents reported were directed at nurses. It appears from the Lion et al. study that all of the incidents reported referred to were in relation to "physical assaults" on staff. In New Zealand, Wills (1987) indicates that 26 percent of staff were assaulted by patients in the preceding 12 months. In Australia, Holden (1985) sent 600 questionnaires to 35 health agencies including hospital and community centres in country and metropolitan Victoria. Findings indicate that almost 73% of nurses were verbally abused, 63% physically assaulted, 43% admitted to being "aggressed" against on one to four occasions in the previous 12 months, while almost 16% reported being "aggressed" against more than 25 times in the same period! Patients accounted for most of the physical assaults on nurses while co-workers were more likely to be verbal abusers. A Queensland study conducted in a large psychiatric hospital between September 1985 and December 1987, estimated that approximately half of the 650 patient-care-related incidents were assault based (Grainger, 1993). Almost eight percent of staff injuries were rated as "severe". The most frequent injury was when a nurse was hit; struck

or punched; scratched, cut or grazed; received an open wound; had limbs twisted, and was kicked. A 12-month study conducted in a large New South Wales psychiatric hospital found that out of a total 227 injuries to nursing staff the majority (82%) were the result of assaults (Lawson, 1992). While the majority of assaults were regarded as "superficial" the author makes the point that assaults are an important occupational hazard in terms of frequency and cost to the health service. When compared to other occupational health injuries, the projected compensational payout for staff assaulted during 1990 was almost $63,000. This compares to almost $15,000 for nurses injured by other means. As well as a dollar cost implication, all assaults, whether classed as major or minor can have lasting psychological consequences for individuals involved. The effect of assaults on staff is discussed below.

A major impediment to establishing accurate estimates of the amount and type of aggression faced by nurses is the under-reporting of incidents. Lion et al. (1981) suggest that only one in five assaults are ever reported. In their study, the officially recorded rate of assaults on staff was 203. Following a three-month scrutiny of daily ward reports they extrapolated a figure of 1,108 assaults for the whole year. In a related discipline, Rowett (1986), also reports considerable under-reporting of assaults by social workers. Under-reporting may occur for several reasons. The issue of aggression in nursing is an emotive one. Nurses are usually thought of as providers of care, not as receivers of help. To admit that nursing care involves being aggressed against is at odds with the more usual stereotype of nursing, which promotes the caring nurse-patient relationship - to admit the spectre of aggression into

this relationship soils the identity of nursing. Jocalyn Lawler (1991), in her book "Behind the Screens" talks of nurses' dirty work; by this she refers to work that remains invisible to outsiders, and is seldom discussed within the nursing literature. Aggression towards nurses can be seen as a "dirty" aspect of nursing too. Until comparatively recently there were very few studies that addressed the issue of aggression in nursing towards nurses (Blair and New, 1992), and today there are few textbooks devoted solely to the topic of aggression in nursing. More specifically, under-reporting may occur when nurses believe that to admit to an assault constitutes professional failure (Drummond et al., 1989) or when they feel colleagues will be unsupportive (Lanza, 1984a). This suggests that nursing staff, following incidents of aggression, may suppress their reactions as a means of protecting themselves from overwhelming anxiety and helplessness. When staff accept aggression as "part of the job" incidents are likely to go unreported too. As one colleague remarked, "Well, you expect to get hit working in a place like this." Also, staff may be reluctant to report incidents where they have to spend time completing a number of forms and reports and where there is no guidance on what to record. Staff are more likely to report only those incidents requiring medical attention (Wenk et al., 1972).

Making comparisons between studies is also difficult because there is inconsistency in the terminology used in relation to aggression. The authors in the Lion et al. (1981) study admit to many methodological difficulties surrounding their study, not least was their definition of "violence" which they defined as physical assaults; had they included verbal abuse in their definition of violence it is likely that the incident of

reported assaults would have been much higher. In the Fottrell et al. study there is a distinction between aggressive and violent behaviours whereas in a study by Casseem (1984) and Pearson et al. (1986) the definitions of aggression and violence are vague. Cox (1987), in a study of verbal abuse among nurses in Texas found that nurses reported high levels of abuse from physicians, patients' families, patients, and immediate supervisors in that order. Cox made the comment that verbal abuse in nursing is so common that it is a wonder anyone stays in nursing. Further, differences between results may be a reflection of different study designs. For instance, during the Fottrell et al. study one of the researchers, who also happened to be a senior nurse manager in the hospital where the study took place, visited the wards daily to ensure that no incident went unreported, whereas Casseem conducted a retrospective study of records. It is perhaps more likely that in the Fottrell et al. study a more accurate estimation of incidents was achieved.

Finally, where studies differ with respect to setting and patient population it is difficult to make comparisons between them. For instance, hospitals may have different admission policies, staff skill mix, use of tranquilliser medication and so forth, thus complicating the picture on incident rates of aggression.

2.8.2 The effect of aggression on nurses

There is an increasing amount of literature describing the negative effects of patient aggression on nursing staff. Lanza (1983) was an early

pioneer in this area. She found that although nurses' reactions following patient assaults can last for some time following the event many nurses reported no responses. In a further study, using an assault vignette as the stimulus material, respondents were more likely to rate their own responses to an actual assault less than the nurse victim depicted in the vignette (Lanza, 1984b). It may be as Lanza suggests that nurse victims of assault are reluctant to acknowledge reactions in themselves for fear of being overwhelmed if they allowed themselves to admit to their feelings or to the fact that they felt that they had no right to react since being assaulted was part of the job (Lanza, 1983). Two studies by Whittington and Wykes (1989; 1992) lend further support for staff denial following assaults from patients. Staff reports of being little affected by aggressive incidents were at odds with their symptoms which suggested otherwise. Cox (1987), in a study of verbal abuse in nursing, indicated that staff nurses initially respond to verbal abuse with assertiveness but quickly resort to avoidance behaviour. Although directors of nursing were inclined to use positive behaviour techniques, avoidance behaviour ranked third on their list of response methods. Flannery et al. (1991) report that hospital staff following assault generally acknowledge feelings of fright, anger and apprehension. Other reactions included, sleep disturbance, intrusive memories and hypervigilence. Among social workers, Rowett (1986) found that respondents reported shock, anger, fear, surprise and panic at the time of the assault. In a review Wykes and Whittington (1995) report that reactions by nurses and other health care workers to assault are similar to those experienced by other victims of assault. They outline the following symptoms culled from published

accounts and from their own experience: anxiety, fear and phobias, cognitive effects, guilt and self blame, anger and morbid hatred.

To overcome problems of recall in research designs, Whittington and Wykes (1989; 1992), contacted staff immediately after an incident and again two weeks later. Their findings indicated that some staff reacted very badly following even so-called "trivial" assaults from patients, with these staff showing symptoms consistent with post-traumatic stress disorder two weeks following the episodes. Ryan and Poster (1989) were able to follow-up their participants for a much longer period. They found that nurse victims' commonest emotional response was anger. This was mentioned by over half of the respondents a week after the incident and one year later 22% of respondents were still reporting this response. Cox (1987) also indicated that for all respondents anger was their initial reaction to verbal abuse.

In general, when victims of assault have admitted their responses, the above findings suggest that they experience both emotional and physiological reactions. These reactions can appear immediately following an assault and last for considerably longer than this. Reactions following aggression from colleagues is hardly addressed in any empirical research in the nursing literature, the study by Cox (1987) is one exception. Cox reported that turnover rates among nurses in her study was directly related to perceived verbal abuse from the nursing supervisors, although nurses' supervisors rated fourth on the list of staff nurses' source of verbal abuse.

2.8.3 The management of aggression

In light of the above, it is not surprising that most of the literature on measures to manage aggression in nursing concentrate on efforts to help nurses better manage their clients' aggression and their own reactions following an aggressive incident.

Wilson and Kneisl (1992), in their discussion on management of aggression within a mental health context, cite the importance of three theoretical formulations, namely, importation; situationism; and interaction - which in ordinary parlance seems to refer to people, place and process. Importation theory suggests that patients bring with them certain values, attitudes, and behaviour patterns conducive to violent outburst in the clinical setting. The second theory, situationism, concentrates on how restrictive hospital environments, for instance, overcrowding, staffing patterns, position of "scarce resources", such as, access to radio and telephone may serve as potential triggers of aggression. Finally, the interactional processes between staff and patients are emphasised; three processes are discussed: provocation; expectations; and conflicts. Provocation focuses on how the nurse may either consciously or inadvertently spark patient assaults. For instance, staff may refuse patients' requests or force clients to do things they do not want to do. Expectations suggests that staff who have persistent expectations about being hit may trigger violence in patients. Such staff may, because of their attitude, provide interpersonal cues that "encourage" patient assault. A similar idea is in Johnson (1990) where he states, along with other researchers, that people who have problems

managing their own anger behave in ways which spark angry and hostile interactions with others. Conflicts, among other things, refer to staff disagreements over philosophical aims. As a result clients may be scapegoated into behaving violently. Wilson and Kneisl suggest an integrated approach based on the frameworks of importation, situationism, and interactionism for understanding and management of patient violence; nevertheless they provide very limited information regarding these concepts, and it is not clear how much of what they say is empirically based.

Another interactional perspective is offered by Lyttle (1986), the author of a popular U.K. textbook on psychiatric nursing, as a precursor to its effective management. He refers to Altschul and McGovern's (1985) ideas when he quotes, "Aggression or violent behaviour can nearly always be traced to disturbances in the relationships between people. Aggression is not an attribute of a person but a response to a frustrating or frightening experience" (p. 119). Nurses are urged to acknowledge how their own behaviour may contribute to incidents of aggression. Two extreme examples, in the guise of nurse Saccharine, and nurse Vinegar, are offered as illustrations of how staff behaviour may provoke anger and aggression. Nurse Saccharine is characterised as being motherly in a superficial way, avoiding getting close to patients and exuding superficial concern. Patients are called "pets", "poor dears", "darlings", or "poor souls". Though well meaning, her stock of unhelpful platitudes ("Never mind, things will look better in the morning", "Every cloud has a silver lining") only serves to alienate patients, making them feel rejected and demeaned. Nurse Vinegar is characterised as authoritarian, rigid,

emotionally inhibited, and very much the "critical parent". This nurse expects patients and others to conform to his or her standards, has a knack of upsetting patients, and is rigidly efficient, and task-oriented in caring for patients. Nurse Vinegar's outward rigidness masks a vulnerable personality that is easily hurt, so (s)he avoids situations that might be emotionally threatening. Nurses are also urged to acknowledge that aggression may be inevitable in close nurse-patient relationship; in these circumstances, the nurse may be viewed as a less threatening object for displacement of feelings. Lyttle [illegible] acknowledges that nurses may be recipients of patients' aggression through no fault of their own, for instance when a patient hits out when drunk or in response to hallucinations.

Farrell and Gray (1992) also stress the importance of an interactional perspective for understanding individual acts of aggression; they emphasise the contribution of the environment, which includes personnel and such factors as noise and temperature; the effects of the patient's emotional and physical state; and the interactions of the nursing staff. They highlight the importance of nurses becoming aware of how their own behaviour may contribute to a patient's aggression and emphasise the importance of good interpersonal skills in the prevention and management of aggression.

In Arthur et al. (1992), the emphasis is on describing the nursing skills and intervention following aggressive incidents "started" by patients. Aggression is seen as something patients bring with them to the hospital. The idea that aggression can arise in ordinary folk under difficult

circumstance is not discussed. Susan Lewis et al. (1989), like Arthur et al. above, see violence as a manifestation of patient attributes, such as, psychotic reactions; personality disorders; brain dysfunction; postictal confusional states (confusion following an epileptic seizure/convulsion); drug and alcohol intoxication; and drug and alcohol withdrawal. In noting that the characteristics of the nurse and the environment in which the patient is nursed are an important consideration in the management of patient violence, most discussion centres on how nurses should *react* to incidents, little attention is given to a discussion of the combined effects of patient characteristics, nurse, and environment in the genesis of aggression nor is there a discussion of the possibility of staff-on-staff aggression.

All of the above texts almost totally ignore that people other than patients may be responsible for some of the aggression meted out to nurses at work. While the importance of good staff relationships and personal awareness may be emphasised in texts, this does not translate into a discussion of how staff themselves may be aggressive to one another.

2.8.4 Horizontal violence

In recent years, the notion of horizontal violence, ie, aggression between nurses, has crept into discourses on the nature of nurses' work (Roberts, 1983; Street, 1992; Walker, 1993; Duffy, 1995). According to Duffy (1995) horizontal violence refers to "overt and covert non-physical hostility amongst staff"(p. 9). This author suggests that, "the nursing world is rife with aggressive and destructive behaviours" (p. 16)

propagated by nurses on nurses. It is contended that because nurses are dominated (and by implication, oppressed) by a patriarchal system headed by doctors, male administrators, and marginalised nurse leaders nurses lower down the hierarchy resort to aggression amongst themselves. This aggression is seen in acts of covert and overt hostility, such as, blaming, bickering, infighting, criticising, undermining, belittling, sabotaging, scapegoating and so on. Almost all of the comment to date on horizontal violence in nursing is based on oppression theory. This forms part of a wider feminist critique of the marginalization of women which holds that individual violence is a microcosm of the power relations in society generally. However, apart from the study by Holden (1985), where nearly 31 percent of nurse respondents reported verbal abuse from co-workers, and Cox's (1987) inquiry into verbal abuse, where nurse supervisors were found to be the fourth most likely source of verbal abuse for respondents, there appears to be no empirical studies which attempt to estimate the extent of horizontal violence in nursing settings and to disentangle it from the aggression nurses receive from other sources. Studies thus far that have commented on horizontal violence in nursing are either anecdotal or else rely on very small sample sizes (Hedin, 1986; Street, 1992; Walker, 1993; Dufffy, 1995).

It is curious that the nursing literature on the incidence of aggression and its management are almost silent on the issue of horizontal aggression. Is it that it doesn't exist or if it does it is not considered as important as patient "initiated" aggression or perhaps, as discussed above, where nurses tended to play down their own reactions following assault, aggression from colleagues is another unmentionable topic.

2.9 Conclusion

The conclusion thus far is that accurate information concerning the definition of aggression within a nursing context is largely absent. There is no clear understanding regarding the nature or type of aggression nurses experience from either patients or others at work (Poster and Ryan, 1993). Most studies concentrate on client assault and ignore the many other possible sources of aggression towards nurses. The possibility of aggression from nurses to others is almost totally ignored. Nurses writing on aggression tend to emphasise the importance of understanding client aggression either in terms of an attribute that patients bring with them on account of illness, or as a feature of nurse-patient interactions and the environment generally. Little attention is given to the possibility of nurse-to-nurse aggression, this includes Farrell and Gray's (1992) text which is one of the few books devoted solely to aggression management within a nursing context. This preoccupation with patient assaults on nursing personnel is exemplified in a major source of aggression literature in nursing, which is incident determination, the effects of aggression on staff and aggression management. Yet, estimation of its incidence is bogged down in a sea of ambiguity concerning what is meant by the term - there is no uniform agreement between studies as to what should be considered as "aggressive". Recourse to expert opinion, whether in nursing or the social sciences, suggests that very few of the formulations on aggression have been subjected to empirical testing. Johnson's (1990) comment on the debate surrounding the links between anger, hostility, and aggression (the AHA syndrome) "in some respects, it is surprising that

the research arenas hosting the discussions and debates over these constructs did not burn down to the ground from all the intellectual heat generated" (p. 15) is fitting for the aggression discourse too.

A dispassionate view is required which empirically examines the extent of aggression, including horizontal violence in nursing. We need to move beyond the rhetoric and begin the task of documenting all aspects of aggression within a nursing context. But first, we need to determine nurses' understanding of the term "aggression". As we have seen this term is a problematic concept, it means different things to different people. However, without this understanding it is difficult to move beyond the general to the particular in discussions about the nature and extent of aggression in nurses' work settings. Clearly, the problem posed for nurse researchers is to develop an understanding of aggression from an emic perspective, ie, one that is in keeping with the "average" nurse's use of the term. It is important to move away from the mainly sterile descriptions offered in many sociopsychological and nursing texts, and to develop an understanding that is based on real incidents. As a first step, it is important that "ordinary" nurses are asked about their experience of on-the-job aggression. Such a descriptive account of nurses' collective wisdom would be a major step forward in determining some of the parameters regarding what constitutes an aggressive act. There is a paucity of information about how nurses view the concept aggression. Most studies generally take the concept as a given - aggression is aggression or rely on the views of theorists outside nursing. Yet social scientists' views on aggression have rarely been

subject to empirical validation away from the laboratory or outside theorists' own minds (Muncer et al.,1986).

Secondly, we need to determine just how concerned nurses are about aggression not just from patients but from all the other possible sources from which it may arise. The question needs to be asked, is horizontal violence a major issue for nurses as some authors suggest? Theorists have addressed the issue from a philosophical stance, it is timely now to see to what extent these views are the reality for nurses working in a range of settings. We should not shy away either from asking about the extent of aggression from nurses to others. Apart from opening up the debate concerning the nature and extent of aggression in nursing, exploration of these issues will have practical relevance for training courses in aggression management. Current suggestions for management of the problem of aggression in nursing are potentially handicapped as they do not consider the possibility of nurse-to-nurse aggression. Most courses focus on client aggression towards nurses only.

2.9.1 Introduction to Phases 1 and 2 of the study

As discussed above, gaining an understanding of aggression is a complex endeavour. Each act of aggression can be considered as an outcome of many interrelated factors. Archer (1989) has argued we cannot adequately understand most acts of aggression or violence. For this author, "real-life acts of violence are embedded in a web of social structures, relationships and interactions that provide them with a setting

which needs to be considered in understanding their meaning" (p. 28). However, this argument is not without its critics. Berkowitz (1989:49) maintains that it is possible to extract out certain features of aggressive acts and draw conclusions about the importance of particular variables in their cause and effect relationships. What Berkowitz and other experimentalists are arguing for is that the causal relationships found between variables will also hold in similar contexts unless there is good reason to think otherwise. Looked at from this perspective the context in which the aggression occurs is of secondary importance unless there is some theoretical reason that suggests that the surrounding situation is a major influence on the variables studied. However, experimentation is likely to be hit and miss without clear theoretical formulations on what the important variables might be. With our present state of knowledge regarding the extent and nature of aggression within a nursing context it would seem folly to embark on experimentation. We do not yet have a clear understanding of aggression from the perspective of nurses themselves.

In light of the above, this study is conducted in two phases. Phase 1 is essentially a qualitative study. The focus of this phase is the everyday world of nurses. The concern is to allow nurses to freely articulate what for them are the relevant issues in relation to aggression. It seeks to contextualize what nurses understand by the term aggression within a clinical context and to assess the importance of aggression from various sources. Where knowledge is sparse on a topic a qualitative method such as grounded theory can help uncover realities and insights into

people's behaviour so that we can begin to document what the relevant issues are from the perspective of those involved.

The ideas gleaned from Phase 1 are used to inform the design for Phase 2. In the second part of the study the views of a larger sample of nurses (n = 270) are compared to those in the qualitative study. In this way, the frequency, seriousness and causal structure of the occurrence of aggression can be estimated. A detailed discussion of the utility of combining different research approaches in this study is found in Chapter 6.

CHAPTER THREE

PHASE 1: AGGRESSION IN NURSING - NURSES' VIEWS

"...You didn't want to get known as a dobber. If you were a student you'd become the target (for other nurses' aggression)..." - a nurse talking about her experiences as a student nurse.

3.1 Introduction

As we have seen, much has been written about "aggression" from a variety of viewpoints, yet little systematic information has been gathered about what nurses in the field see as "aggression". Few studies have asked "ordinary" nurses for their views about the nature and extent of aggression in their clinical settings. In light of this, it was decided to adopt an essentially inductive method to name concepts and identify their characteristics within the reality of the context in which they occur. The methods of a grounded theory approach were adopted. In essence, these are similar to many other qualitative approaches. They attempt to identify properties existing in the real world and gain a fuller understanding as to what constitutes reality for the informants in a particular real-life setting (Field and Morse, 1985).

3.2 A method for finding out: grounded theory

Grounded theory is an inductive approach to theory generation. It is used when little is known about the phenomena under investigation, ie, before the central conceptual issues have been addressed. Using a grounded theory perspective, ideas and hunches are checked out during data collection and analysis as one moves cautiously from provisional ideas to theoretical insights. There is a reciprocal relationship between data collection, analysis, and theory generation (Strauss and Corbin, 1990: 23). Ideas begin to merge and patterns develop as the study develops. To avoid getting side-tracked during data collection, Strauss and Corbin (1990: 38) recommend that the researcher directs questions that retain the central focus of the interview, in this instance, perceptions of aggression.

By laying the data out in narrative or graphic fashion, the researcher can make statements about relationships and these can be assessed to see if they are validated by the data. It is in the arranging and rearranging of the conversational exchanges between her/himself and respondents that the researcher ensures that they make sense, both sequentially and analytically vis-a-vis the central story line. With this systematization and ordering of the data it is almost inevitable that patterns will emerge in the data prior to the final telling of the "story". The essence of grounded theory is the making of comparisons and the asking of questions, ie, the constant comparative method of analysis (Glaser and Strauss, 1967: 101-115).

Glaser and Strauss (1967) and Strauss and Corbin (1990) emphasise the importance of theoretical sensitivity. Essentially, theoretical sensitivity refers to the insight and understanding that researchers bring to the data analysis as a result of their reading or their personal or professional experiences. Such sensitivity can be further developed as the research proceeds and the researcher interacts with the data. However, caution is warranted lest researchers because of their prior knowledge become so heavily influenced by it that they rush past "diamonds in the rough" when examining the data (Strauss and Corbin, 1990: 77). To enhance theoretical sensitivity, Strauss and Corbin recommend strategies, such as, maintaining an attitude of scepticism and looking at the situation from different perspectives - similar notions applicable to all research. In the present study the researcher sought the views of those in a position to give wise counsel about the findings. For instance, some of the findings were shared with the hospital staff counsellor to see if the researcher's conceptionalizations about them were in keeping with what (s)he might expect such a study to unearth.

In research there is always a trade-off in deciding how many respondents to include. Where samples are small detailed information can be gathered on respondents' views, however it is not possible to be sure that the information will be applicable for those omitted from the study. In general, with a large sample one can be more confident that one's findings are true but the opportunity is normally lost for in-depth study of those concerned (Cherniss, 1995: 6). Because the present investigation was essentially after depth rather than breadth an upper limit of 30

respondents was deemed an appropriate number to be interviewed. In actual fact 29 respondents took part in Phase 1.

3.3 University-based nurses' opinions of aggression in the clinical setting: questionnaire results

In an attempt to generate interest in the study and to provide a focus for the interviews to come, all nurse colleagues in the university department where the researcher worked were mailed a short questionnaire asking them to document incidents of aggression that they had witnessed or had been personally involved in (Appendix 1). Questionnaires asked respondents to say who was involved in the incident, what actually happened, how the incident was resolved, what happened after the incident, and to rate how serious the incident was on a visual analogue scale. To help ensure that respondents were as free as possible of researcher-imposed biases about what to record, they were not supplied with a definition of aggression. Nine incidents of aggression were outlined by nine colleagues, representing a 31 % response rate.

Initial analysis of the completed questionnaire revealed the following breakdown of incidents in terms of who was aggressive to whom: patient-to-nurse aggression accounted for three incidents; doctor-to-nurse aggression accounted for two incidents. The remaining four incidents reported included, midwife-to-midwife aggression, nursing-staff-to-patient aggression, client-to-client aggression, and finally, one incident referred to the potential for aggression following the sighting of a male intruder in

the nurses' quarters of a rural nursing station. In terms of their seriousness, all were rated as very serious or potentially so.

3.4 Interviews with university nurses

All respondents to the questionnaire agreed to a follow-up interview. Each interview was begun along the following lines, "Thank you for agreeing to be interviewed. I'd like to take this opportunity to explore further your experience of aggression in the clinical setting. Your completed questionnaire refers to ..., is there anything else you'd like to add concerning this incident?". Interviews were conducted in private, in comfortable surroundings, free from interruptions. All interviews were taped with respondents' permission. Interviews lasted approximately one hour. Interviewees were encouraged to discuss the things they felt were important. To this end, the researcher used "encouragers", such as, "I see", "Right", "Mm" and silence. As far as possible, shifts in topic were occasioned by the interviewees. All respondents were invited to talk about other incidents of aggression that they had witnessed or been personally involved in. They were asked about their personal safety at work, their usual coping strategies following incidents of aggression, and whether they reported all incidents. Interviewees were asked to complete a short questionnaire (Appendix 2) which consisted of four questions regarding the extent of aggression that in their opinion could be classified in terms of: patient-to-staff aggression, patient-to-patient aggression, staff-to-patient aggression, and staff-to-staff aggression. Questionnaire items used the generic label "staff" rather than "nurse" when asking respondents to comment on their experience of aggression so that as

wide a debate as possible could ensue. However, it soon became apparent that respondents focussed on aggression in relation to nurse colleagues; that doctors or others were aggressive or had been aggressed against was not a main concern of respondents. For each item respondents were asked to place an 'x' on a 7 cm visual analogue scale which ran from: aggression extremely unlikely to aggression extremely likely. Further questioning elicited what they considered to be of central importance for nurse researchers wishing to conduct a study of aggression in nursing. A final question asked if there were other aspects of aggression not thus far covered that respondents would like to discuss.

3.5 Preliminary analysis of interviews with university nurses

Preliminary analysis of interviews suggested that respondents are most concerned surprisingly, perhaps, in light of the incidents outlined in their questionnaires, about the extent of intra-staff aggression, that is, aggression by nurses towards nurses. All respondents thought such aggression was more upsetting and problematic to deal with than patient-to-nurse aggression. Indeed, the majority of respondents reported that there were more acts of aggression between nurses themselves than patient-to-nurse aggression. Respondents were concerned both about the number of incidents of aggression that they had to face and annoyed that when incidents did occur their fears and feelings about the event were almost totally ignored by their nurse managers. Respondents reported an almost total lack of debriefing on the part of their nurse managers following incidents of aggression.

Managers failed to acknowledge that staff might be upset following their report of an incident of aggression either from patients or from their colleagues (The role of aggression management is discussed in more detail below).

Three respondents raised events concerning their level of vulnerability to attack, from patients or members of the public, while working in isolated areas both in the metropolitan and rural/remote settings. Their tales are disquieting not only from the point of view of the present disturbing accounts but also for the fact that these respondents were reporting on situations that were not unique to them. It would appear there may be many (hundreds of) nurses currently working in similar risky situations, and if a serious incident is not to occur urgent action is required. The cliche "an accident waiting to happen" is apt in this context.

There were some reports of staff-to-patient aggression particularly in areas where patients were longstay or when patients had "trying" conditions. While this level of aggression reported was low in comparison to nurse-to-nurse aggression, it might be argued that even one such incident is one too many.

As expected, nurses included both physical and verbal components when discussing individual incidents of aggression. At no point did the researcher offer a definition of aggression to respondents and it became evident that an "omnibus" concept like aggression is best defined in terms of what people say it is.

The extent with which respondents reported intra-group aggression surprised the researcher. At the start of this project this issue was not thought by the researcher to be a central concern. There is scant attention given to intra-group aggression in empirical nursing literature, the main focus being on patient aggression and its management. In the researcher's experience in mental health nursing this staff-on-staff conflict was not a concern, except for a two-year period when working in the general nursing setting a common remark made by a nurse colleague was, *"With a little more effort they (other nursing staff) could be really bloody minded"*. Also, the intimidation exercised by some ward sisters on junior staff springs to mind. Junior staff were frequently expected to stay on duty long after their work shift had ended. Many colleagues in training were in fear of getting a poor ward report if they didn't "behave" themselves, - which meant doing what you were told to do with good grace and without question.

In the present study, both mental health and general nurses reported similar levels of aggression and intimidation amongst their colleagues. All respondents were at pains to point out that any study of aggression in nursing should focus attention on nurses themselves. Intra-staff hostility was cited as the most important consideration. While patient aggression towards nurses occurred (see below) it was felt marginal compared to respondents' concerns about the perceived high level of intra-group conflict. As one respondent put it,

The first thing that comes into my mind when thinking about aggression in nursing is staff-to-staff (aggression) and another said,

I want to reinforce that there is far more aggression and violence than we recognise (among nurses) and I hope that someone is going to address that.

Recall, respondents were asked to complete four visual analogue scales regarding their experiences of aggression. Results from this exercise endorse what respondents communicated verbally (Table 3.5.1).

Table 3.5.1 **The Average Likelihood of Occurrence of Each Item (n = 9)**

Aggression from:	Mean score
Patients-to-staff	2.46
Patients-to-patients	1.75
Staff-to-patient	2.34
Staff-to-staff	4.37

Note: Each visual analogue scale measured from left to right - zero to 7 cm. Xs lying exactly at the left hand end of the scale scored 0 indicating that the respondent thought aggression extremely unlikely, xs lying near the right end of the scale indicated that aggression was extremely likely. For each of the four questions respondents' x positions were measured and averaged.

Respondents were asked to speak about the aggression that they had either experienced themselves or had seen some of their colleagues fall victim to. Reported was a virtual battlefield of innuendo, put-down, threat, intimidation, and sadly, actual physical violence perpetrated by nurses on nurses. The hardest thing to deal with, according to respondents, was not the physical attacks - of which there were few reported, but the non-physical acts of aggression. Respondents were more concerned about the all pervasive hostile undercurrent of what can best be described as professional terrorism.

3.5.1 Professional terrorism

The notion of professional terrorism (PT) was a key concept that emerged from the data. This concept is used to denote respondents' feelings about the way they felt colleagues intentionally sought to undermine their self worth by acts of "aggression", as one respondent put it: *"Nurses can be very destructive towards one another"*. Another respondent tried to reconcile nurses' proclamations of being in a *"caring"* profession with the aggressive behaviour of her colleagues.

> *When I worked in large hospitals many years ago I can't remember that sort of thing going on, there was a solidarity there, it was all up front. Now that we are all more caring we don't confront each other in quite the same way... well it's like not acceptable behaviour but we got to get the violence out somehow.*

Getting the violence out as the above respondent put it took the form of direct and indirect expression.

3.5.1.1 Aggression: direct and indirect dimensions

An example of the direct way in which staff could be aggressive towards one another is illustrated in the following two examples:

> *On one occasion she (a nurse colleague) came up to be me and belittled me in front of others, she was like that....* and

> *I asked her to help me with this particular patient but she pretended not to hear ,...and she strode off. ..*

However, the concern of many respondents was the undercover way in which colleagues attacked them as the following two comments from respondents illustrate:

> *I've witnessed quite a lot...you see one person putting another person down by raised eyebrows, snide remarks and turning away, it goes on all the time,* and

> *In the agency in which I work people (other staff) will come to me and there are little innuendos dropped about someone's performance, maybe just a raised eyebrow or a shrug ... that can be very destructive... and things like, "Oh, I wouldn't ask her" accompanied by a little smile and you*

are left wondering why or what... and that sort of thing goes on all the time.

It seems subscription to a "caring" role precludes up-front confrontation. Instead we seek underhand though ultimately more destructive ways to deal with conflict. This latter view is echoed by the respondent who complained about the

...damage done w*hen one's self esteem is undermined by colleagues.*

3.5.1.2 Aggression: active and passive dimensions

Many of the acts illustrated above can be seen as an active attribute. They consist of or are marked by an action (COD, 1991) on the part of the "aggressor". However, not all acts of aggression were conceptualized in this domain. Aggression was inferred when others failed to take action. In this sense, colleagues were being criticised for acts of omission as much as for acts of commission. The reluctance of some nurses, and in particular some nurse managers to openly acknowledge conflict was exemplified for many respondents through colleagues' failure to stand up for each other in their absence or when nurse managers failed to acknowledge that staff may be upset following aggression from patients. Respondents who had worked in rural or remote areas recounted similar tales to their hospital-based colleagues about the lack of recognition by their managers of their needs following incidents. One respondent noted that while debriefing meetings

occurred within her own circle of close colleagues managers were unlikely to initiate such meetings.

> *The only team meetings happened within one's own team. I've thought about that a lot, you might imagine that support may have come from managers yet a lot of tensions I guess you could relate to the structure they (managers) imposed on us. We were working extraordinary hours and there was so much structure imposed on us from management that this added to the tension. They probably were not seen as an ally.*

Because staff-on-staff incidents rarely get brought out into the open the hospital staff counsellor was used by some respondents as a sounding board when problems arose. Where staff feel that the only option is to air their grievances to the staff counsellor there is a danger that what may have started out as a relationship issue for all concerned gets transformed into an individual's personal problem. When this happens nurse managers and for that matter nurse colleagues can distance themselves from the part they may have had to play in the problem arising in the first place. Thus, the person seeking help is seen to have a problem. One normally resourceful and by all accounts highly competent respondent admitted needing professional help to try and cope following his manager's blatant attack on his professional nursing skills. Consequently, this colleague went off on stress leave and for a time doubted his own ability to cope. Yet, from all the evidence available, this person would seem to have good grounds for claiming harassment.

When issues such as this are allowed to ride, outwardly, at least, it is the victim that gets targeted as being in need of help; the fact that the manager may be incompetent or worse (eg, vindictive) is allowed to slide by.

3.5.1.3 Aggression: physical and verbal dimensions

The majority of the incidents reported related to verbal acts of aggression. However, a few respondents intimated that they believed some of their colleagues were subjected to physical attack. One respondent, although without actually witnessing the event himself, related the tale where "fists had flown" when a colleague of his was taken into the ward office by a group of male nurses. Another respondent reported that a colleague of hers had the wheels of her car tampered with after she complained about nurses' rough treatment of patients. This latter account is particularly disquieting in that it illustrates just how far people may go in their intimidation of another.

What are we to make of these reports? Are respondents over-reporting such incidents, or are they perhaps, overly sensitive to the sometimes abrasive nature of a busy hospital environment and in consequence leaving same for the relative safety of academia? In answer to the first possibility it seems unlikely that all respondents would independently choose to label aggression by nurses as the most important consideration. For some it appeared a painful process to recount tales about their own colleagues' aggressive behaviour. All respondents were aware that some of what they said might be "written up". It would be

surprising if they all wanted to deliberately mislead the investigator by casting aspersions on their own profession. In answer to the second possibility, maybe these respondents are more sensitive to the hurly burly of clinical life compared to their permanently based clinical colleagues. One respondent commented that many of her colleagues in teaching were reluctant to return to the clinical setting for fear of having to deal with the hostility there. Others commented that they felt valued as people in academia. In the clinical setting acknowledgment of their worth was rare. It seems colleagues and nurse managers are quick to criticise but slow to praise in the clinical context.

3.6 Interviews with clinical nurses

In an attempt to see if current hospital staff hold views similar to their academic colleagues, the researcher contacted a number of staff in a large general hospital in Tasmania in order to ascertain their views about aggression. The director of nursing's permission was sought to approach staff during their work time. Staff from three wards were contacted at handover times by the author. The author explained to them that he wished to hear their views regarding the nature and extent of aggression they had been personally involved in or witnessed while at work, and that this information would provide the basis for a larger study on the topic. As with the sample of university-based respondents, a definition of aggression was not given to these nurses. Opportunity was allowed for staff to raise questions and for those willing to be interviewed a mutually convenient time was negotiated. Staff from two medical wards and from an accident and emergency department agreed to take

part. In all, 20 staff were interviewed and many more staff voiced their willingness to be contacted if required at a later date. Some staff elected for a group interview. This may reflect the fact that staff felt more comfortable discussing this topic with others present because the researcher was an "unknown" to them. Interviews with clinical staff were shorter than those with their university-based colleagues, on average both individual and group interviews lasted approximately 15 minutes. Clinical staff interviews were not taped and the researcher made the minimum of notes during these meetings. Copious jottings were made at the end of each meeting.

Unlike their university-based colleagues, clinical staff were not given a questionnaire to record their experiences of aggression prior to interview because of time constraints and the difficulty of reaching staff who were working shifts. However, like their university colleagues, they were each given a similar visual analogue scale to complete on their own during the course of the interview. As can be seen from Table 3.6.1 below, clinical staff rate aggression from patients to nurses higher than staff-to-staff (nurse-to-nurse) aggression. And both groups of nurses single out patient-to-staff aggression and staff-to-staff aggression as being the most likely occurrences of aggression in the clinical setting. When scores are aggregated for each group of nurses staff-to-staff aggression is thought to occur most often (Table 3.6.1).

Correlation of the above data indicates a moderate degree of agreement between the university and clinical staff ($\underline{r}$ = .517). As can be seen from the table below, the largest differences between groups are the scores

for patient-to-staff aggression and staff-to-staff aggression. Why these discrepancies? First, it has to be noted that we are not comparing representative groups. Therefore, the above results may simply be pointing to an artefact of sampling error as opposed to there being a real difference between the groups. Second, it was suggested above that any differences found between

Table 3.6.1 **Comparison of Mean Scores for University-Based and Clinically-Based Staff**

Aggression from:	University-based staff	Hospital-based staff	Total
Patients-to-staff	2.46	3.93	3.47
Patients-to-patients	1.76	1.93	1.88
Staff-to-patients	2.34	1.85	2.00
Staff-to-staff	4.37	3.36	3.67
	n = 9	n = 20	N=29

the university-based nurses and their clinical colleagues may be a reflection of the former nurses being over-sensitive to colleague aggression. This is a possibility, as people who stay in the clinical arena may be more tolerant of colleagues' aggression. Third, being closer to the "action" may not afford clinical staff the opportunity to reflect on their situation in quite the same way as their university colleagues.

But the differences above in Table 3.6.1 hide an important area of agreement between the two groups of nurses. When the issue was first raised with clinical staff at handover many asked, "jokingly", if I was interested in hearing about aggression amongst staff. What became

clear during discussions with the majority of clinical nurses was that intra-staff aggression was more problematic to deal with than any other aspect of aggression they experienced. Like their university-based colleagues, these staff said that intra-staff aggression warrants a much larger press than it has previously had. One respondent suggested that there was an increasing amount of *"good"* literature and advice surrounding the management of patient-to-nurse aggression but there was precious little help and advice available on how to manage intra-staff conflict and aggression.

In summary, it was remarkable just how similar each group was in describing its experiences of aggression from colleagues and the overall lack of support that they had from nursing management when incidents occurred. Aggression from other disciplines was not thought of as a real problem compared to that experienced on a day-to-day basis from their colleagues, although doctors were frequently mentioned as being *"difficult"* too.

Differences in overall mean scores between settings may also be accounted for in terms of some staff reluctance to admit to intra-staff aggression to an "unknown". Most of the university staff interviewed were known at least on a "good morning" basis to the researcher, whereas clinical staff were not acquainted with the researcher prior to the interview. In a few of these interviews, a couple of senior staff nurses became defensive when questioned about the provision of debriefing sessions following incidents of aggression. Answers to this question were often personalised, as in *"I always do it when I'm on"* or *"Nurses*

don't always need it". These staff evaluated staff-to-staff aggression as very low compared to patient-to-staff aggression.

3.7 Female and male views

It was discussed above that gender and individual differences were less likely to have a bearing on one's aggressiveness compared to the environment in which one lives. The idea being that we are more a product of our environments than perhaps we care to imagine. In the present study the male respondents (n = 5) had broadly similar stories to tell regarding the nature and extent of aggression in the clinical setting. And both male and female respondents remarked that it was easier to work when there were both males and females about. Many commented, for example,

> *There is less bitchiness when there are male nurses about,*
> and
>
> *I think it is important that each ward has male and female nurses on duty because there's less bitchiness.*

These appear to be fairly pervasive sentiments among nurses (Duffy, 1995: 9). In light of nurses' unexpected comments about their colleagues' aggression the author began to wonder if he'd happened upon an "extreme case". A personal communication with a fellow PhD student (Cecil Deans) on the mainland of Australia, who is conducting a study into the effects of aggression on nurses, reassured me that my

preliminary findings were similar to what he would have expected. He too was surprised by the level and frequency of nurses' reports of intra-group aggression. It was not unusual for him in his role of workshop facilitator on how to handle patient aggression, to be asked by the group to talk instead about how to handle staff conflicts. In the USA, Smythe (1984: 225), came across a similar phenomenon. During workshops she ran on stress management nurses of various levels frequently remarked to her of the abuse they received from nurse colleagues. It would appear that nurse-to-nurse aggression and conflict are not confined to Tasmania.

It is interesting to note that simply asking nurses to record their experience of aggressive incidents may not elicit their true concerns. Recall, that the breakdown of the university-based nurses' questionnaire responses included only one incident of nurse-to-nurse aggression, it was not until the one-to-one discussions that the issue of staff aggression arose. In the clinical setting staff were more relaxed in discussing colleague aggression after the subject had been raised by one of their colleagues during the group discussions. Perhaps, this reflects the fact that staff-to-staff aggression remains a taboo subject for many nurses, certainly not a polite topic of conversation with a relative stranger. Andrea Adams (1994), writing on abuse in the workplace, was astounded by the response following her radio programme on the subject in the U.K. She recalls that most of the telephone calls and letters that she received were from women and men who had never before felt able to tell their stories.

3.8 Conceptualizing aggression in the clinical setting

Thus far the emphasis has been on describing respondents' experience of aggression. It is timely at this juncture to begin to bring order to the varied descriptions of aggression given.

3.8.1 Typologies of aggression

Although the freedom to define the concept "aggression" allowed a variety of incidents to be raised, it was nevertheless possible to conceptualize them along the lines offered by Buss (1961). According to Buss aggression can be dichotomised along three dimensions; physical-verbal, active-passive, and direct-indirect. Combining these dimensions results in eight possible categories of aggression into which most, if not all, aggressive behaviours mentioned by respondents can be placed (Table 3.8.1).

Examples of the aggressive dimensions are illustrated below. It should be noted that Buss's conceptualization of aggressive acts is but one typology; there are many more, for instance we could add intent to the above classification as in hostile versus instrumental aggression. When the primary goal is to cause harm, suffering or injury to another the aggression is labelled as hostile, whereas instrumental aggression does not have as the primary goal the infliction of harm - the aggressor in this instance uses aggression to obtain other goals.

Table 3.8.1 **Different Types of Aggression (After Buss 1961).**

TYPE	EXAMPLES
Physical-active-direct	Stabbing, punching, or shooting another person.
Physical-active-indirect	Setting a booby trap for another, hiring an assassin to kill an enemy.
Physical-passive-direct	Physically preventing another from obtaining a desired goal or performing a desired act (as in a sit-in demonstration).
Physical-passive-indirect	Refusing to perform necessary tasks (eg, refusal to move during a sit-in).
Verbal-active-direct	Insulting or derogating another person.
Verbal-active-indirect	Spreading malicious rumours or gossip about another.
Verbal-passive-direct	Refusing to speak to another, to answer questions, etc.
Verbal-passive-indirect	Failing to make specific verbal comments (eg, failing to speak up in another's defence when he or she is unfairly criticised).

(Ref: Baron, R. A. (1977) Human Aggression New York, Plenum Press, p.11)

For example, a bank robber may cause suffering to the cashier in his attempt to secure cash. This added dimension would lead to 16 types of aggressive acts. To this list we could also add short versus long-term aggression and group versus individual aggression - making a total of 64 types of aggression - and so on. For the present we will confine ourselves to Buss's typology. Our concern at this juncture is to offer an

overview of the nature and types of aggressive issues nurses are concerned about.

Descriptions of aggressive behaviours relayed by respondents that clearly illustrate their inclusion into Buss's typology are outlined here: staff screaming abuse at one another within earshot of patients (an example of verbal-active-direct aggression); staff being punched by colleagues because they *"didn't fit in/conform"* (physical-active-direct). Other respondents were troubled by colleagues *"who talk behind your back"* (verbal-active-indirect) and the aggression inherent when a colleague "*...withheld information about another nurse in order to detrimentally affect that colleague's career*" (verbal-passive-indirect aggression). *"Refusing to lend a hand*" say, with turning a patient in bed (physical-passive-direct); refusing to speak to or converse with colleagues (verbal-passive-direct); refusing to move out of the way of another (physical-passive-indirect) were other instances of staff aggression recounted by respondents. The practice of some ward charge nurses/managers to keep junior staff on duty when they had officially finished their shift can be considered as an instance of physical-passive-direct aggression or where staff are kept waiting without explanation long past their appointment time with a manager .

Reports of aggression and intimidation were not always confined to the work place. One respondent told of having a load of dead fish dumped on her lawn and a *"For Sale"* sign erected by her house during her involvement as a manager in a staff reprofiling exercise (physical-active-indirect aggression). Another respondent recounted the potentially fatal

outcome when her friend had the wheels of her car loosened because it was thought she had *"dobbed in"* on her colleagues' aggressive behaviour to patients; it was only after she had driven home that she realised that the wheels of her car had been tampered with (physical-active-indirect aggression). In summary, all of the categories of aggression as outlined by Buss were represented for in the reports from these respondents.

3.8.2 Aggression defined

Aggression, according to these respondents can be defined thus: to deliberately cause psychological or physical harm to another through verbal and non-verbal acts. Such acts may be direct or indirect and be active or passive. This is very much in line with the typology above, however, within a nursing context this definition is almost exclusively reserved for nurse colleagues. Patients, although thought of as aggressive were in many instances excused for their behaviour on account of factors (ie, illnesses) outside their control. A couple of respondents put it thus:

> *I think I might be aggressive if I had that condition*
>
> and
>
> *It is no joke being a patient and having to conform to hospital rules.*

So if the person's illness wasn't to blame then the system was. One might also infer from this that these nurses have the expectation that

aggression is a natural accompaniment of being ill. When aggression is directed at nurses from patients' relatives many respondents were quick to suggest that the relative was either *"anxious or getting at the system"* and not at them personally:

> *In midwifery I've had to deal with very aggressive men, well you know it wasn't a problem. I could deal with something like that and turn around and it would be forgotten...*

Therefore, it may be more appropriate to think that nurses view patients' (and their relatives') aggressive behaviours as akin to letting off steam or as emotional expressions of an underlying disorder and unconnected with wanting specifically to hurt the nurse. On the other hand, when nurse colleagues were thought of as aggressive their aggression was described as an attribute of the person's personality, as in *"nastiness"*.

3.8.3 Nurses' aggression as an instance of rule breaking.

On a more practical level, one can think of most of the acts thus far reported as colleagues breaking *relationship rules* at work. A major concern raised by many respondents centered on what would seem to be poor work relationships. Edelmann (1993) suggests that in work relationships there are general rule categories which apply. *Rules of support* in which colleagues help one another out in work-related tasks, or they may offer advice, guidance and maybe emotional support, and stand in during a colleague's absence. *Rules of intimacy* refer to respect for another's privacy, and refraining from engaging in sexual activity with

co-workers unless there is active agreement and encouragement from both parties and when such relationships do not interfere with working practices. *Rules relating to third parties* asks that employees be aware that work relationships rarely exist in isolation from the broader social context and that people outside our work relationships can have a major effect on our immediate relationships, therefore we should refrain from criticising our colleagues in public, not to disclose what has been told to us in confidence, and to stand up for colleagues in their absence. Finally, *task-related rules* refer to the general acceptance that in all professional relationships, be they teacher-pupil, lawyer-client or nurse-patient, both the professional and the recipient of the "service" will abide by certain rules in order to complete (a) specific task(s). For example, teachers are expected to prepare lessons and mark assignments, students are expected to be willing to learn and to hand in work on time. Transgression of these rule categories leads to conflict, and in the case of the rules pertaining to teacher-pupil relationships, teachers who "break" the rules are liable to be "punished" by the pupils in terms of verbal insults, creating disorder, or even physical violence (Argyle and Henderson, 1985: 268). In interviews with respondents, it was apparent that what was being reported was both a catalogue of "incidents" as well as examples of blatant rule breaking across at least two of these categories namely, *rules of support and rules relating to third parties.*

To make the best of work relationships Argyle and Henderson (1985: 255) suggest that there are at least 15 rules expected of co-workers as listed below (Table 3.9.1).

Table 3.9.1 Rules for Co-Workers (Argyle and Henderson, 1985)

1. Accept one's fair share of the work load.
2. Respect other's privacy
3. Be co-operative with regard to the shared physical working conditions (eg, light, temperature, noise).
4. Be willing to help when requested.
5. Keep confidences.
6. Work co-operatively despite feelings of dislike.
7. Don't denigrate to superiors.
8. Address the co-worker by first name.
9. Ask for help and advice when necessary.
10. Look the co-worker in the eye during conversations.
11. Don't be over-inquisitive about each other's private lives.
12. Repay debts, favours, and compliments no matter how small.
13. Don't engage in sexual activity with the co-worker.
14. Stand up for the co-worker in his/her absence.
15. Don't criticise the co-worker publicly.

Almost all of the above rules, except perhaps for rules 12 (in relation to repayment of debts) and 13, were broken according to respondents' reports of their colleagues' behaviour.

The above accounts graphically illustrate the plight of respondents. However, before attempts to effect change in nurses' working relations it

is important to situate the occurrence of aggression within a nursing context (Chapter 4).

CHAPTER FOUR

WHY DON'T NURSES PULL TOGETHER MORE?

4.1 Introduction

In the above discussion a descriptive overview is provided of the aggression nurses mete out to each other. In this chapter discussion focuses on some possible reasons for why nurses behave as they do.

4.2 Nursing as an oppressed discipline

One respondent related how, following the introduction of new work practices, she experienced hostile resistance from her nurse colleagues and not as she had imagined from doctors:

> *It was almost expected that obstetricians would have some resistance to these new work practices as it was taking over an area that they have a lot of control over ...I guess it was a natural thought, but we never thought we would get so much resistance from our nurse colleagues. I remember thinking that I can't believe I'm getting more support from obstetricians than from midwives.*

This statement begs the question in the title of this chapter. The discussion below offers some possible answers.

Roberts (1983) suggests that intra-staff conflict in nursing is characteristic of their oppressed status. She cites Fanon (1963), when accounting for nurses' hostile behaviour. Fanon draws on the notion of the "hydraulic model" of aggression to explain "horizontal violence" among colonised groups. Fanon suggests that native groups engage in constant inter-group conflict as a way of releasing tension that has built up because of the group's inability to attack the oppressor, thus ensuring the self-fulfilling prophecy of the dominant group, ie, such people cannot be trusted to look after themselves. Nurses, like other oppressed groups, exhibit self-hatred and dislike for other fellow nurses (Roberts 1983: 23). Note, horizontal violence is used in this context to denote aggression within and between the different grades of staff nurses, ie, aggression can be top-down, bottom-up or between staff of equal grade. In the present study, some respondents felt that they were the *"meat in the sandwich"*, aggression being directed at them from below from patients and relatives and above from management and from doctors and other professional groups.

Horizontal violence as a feature of oppressed group behaviour may perhaps be useful in providing a macro explanation of intra-nursing aggression. Aggression is seen as a result of nurses' marginalization vis-a-vis other more powerful professional groups, such as, the male-dominated medical profession. One respondent summed up the situation thus:

Women, nurses and midwives have a shared struggle in terms of oppression and dominance and that's as far as I've come in working that one through.

Moreover, nursing, being a largely female occupation, is prey to sex role stereotyping by dominant males. Kanter (1979) suggests that women are often assigned four stereotypical roles in the workplace which militate against them being seen as equal workers alongside their male coworkers. The "mother earth" role depicts women as nurturing and caring; whereas, the "seductress" role defines women as sex objects whose role is to titillate men at work - women cast in this role may be victims of sexual harassment which, although perhaps, not on the increase is seen as a major source of work conflict. Women in the "pet" role are treated more as decoration than as equal partners. Should a woman not accept either of these roles she is cast as the "iron maiden" - tough, dangerous, and unfeminine.

Borgotta and Stimson (1963) suggest that women are competitive with other women when in male company, yet are collaborative when interacting with men alone. From the perspective of oppression theory, such remarks signify female nurses' ignorance of their disadvantaged status. Speedy (1987 cited in Duffy, 1995) urges nurses to "recognise their self-flagellation and infighting as being symptomatic of the more general social problems of women, rather than the idiosyncratic and personal traits of certain nurses" (p. 9). A similar view is adopted by Redland (1982, cited in Cavanagh, 1991) who investigated nurses' interaction styles with physicians - she suggests that such

accommodating behaviour among female nurses with male physicians is an example of stereotypical dependent behaviour, in this case, the female nurse seeks rewards or favours from the organisationally superior male.

At issue for many writers on gender differences at work is the inherent imbalance in power relations between men and women. They point out that traditionally men have exercised power over women thereby placing women in inferior and in vulnerable positions relative to men. Nursing is seen as a case in point.

However, oppression theory may be but one consideration in understanding horizontal violence among nurses. In the example above where it was suggested that female nurses were "accommodating" when working alongside male physicians, communication theory may throw light on this phenomenon too. Recall, both female and male respondents said that work was more enjoyable when both sexes were on duty. In light of the speculation above regarding differing communication styles (Chapter 2), it might be that the payoff in having both sexes present in the work environment outweighs any inherent problem that might exist over differing communication patterns between the sexes. Women tend to be more involved in the social side of work relationships whereas men tend to enjoy working in groups more (Henderson and Argyle, 1985), both important in an organisation that stresses individual and team-work. Differing communication styles, if these really exist, may flourish more when there is opportunity to balance the needs of the organisation with those of the individual.

Moreover, a call for a gender mix may be related to a basic drive; in other words, it may simply be a coded signal for wanting the opportunity to "court" the opposite sex. Our friends and lovers are usually those who live or work near us (Lippa, 1990: 428).

It is important that in any systematic examination of aggression or conflict in nursing that we do not overlook some of the factors inherent in groups themselves, that is, we include inside factors as well as outside factors for analysis. Support for this view is evident when we consider notions of the "unpopular patient". Nurses may take their feelings of powerlessness and inferiority out on patients too, but the literature here suggests that some patients bear the brunt of abuse more than others (Kelly and May, 1982). Similarly, aggression between nurses may be selective and be accounted for in terms of factors inherent in the work situation or the person or in personal interactional styles.

To say that nurses are an oppressed group and that this is why they "exhibit self-hatred and dislike for other nurses" (Roberts, 1983) does not go far enough. Even if we accept that nurses are marginalized compared to the power wielded by physicians, it is unlikely nurses will be in a position to do much about redressing this power imbalance before confronting conflict within their own ranks first. It is contended that nurses need to articulate the issues to themselves prior to tackling redress on the larger stage vis-a-vis other professional groups. Kohnke (1981) maintains that it is not enough for nurses simply to publicise their suffering within the health care system; the abuse from within their own ranks must also be acknowledged and eliminated. What Kohnke seems

to be suggesting is that nurses have to take responsibility for their own actions regarding abuse and conflict. This view suggests that it is possible to do something about interpersonal conflict without necessarily having to dismantle the prevailing hegemony of any alleged oppressor. Of course, if it was the case that nurses' main concern in the present study was one of sexual harassment by "powerful" male doctors then clearly a major solution would be to take the perpetrators to task. Smythe's (1984) contention is that it is the very practice of our nursing care that is at fault in accounting for nursing's disunity and endemic conflict.

4.3 Disenfranchising work practices

Much of nursing care is institutionalised and rule dominated. Perry (1986) argues that nurses too readily accept taken-for-granted practices and institutional rules thus contributing to their own domination. Smythe (1984) notes that it is frequently the case that specific tasks and responsibilities are assigned to different nurses so that, for instance, junior nurses are assigned the less pleasant tasks of patient care. This might include emptying bedpans, giving bed baths and answering call lights. The more senior nurses perform so-called higher status tasks, such as, giving medication and communicating with doctors on the premise that these tasks require more expertise. The highest status tasks, those of co-ordinating and giving orders are normally performed by the highest status ward nurse - the level three nurse (clinical nurse manager or in earlier parlance, the charge nurse).

From my own observations, much of nurses' work can be seen to centre around task/time parameters. Street (1992: 102) makes a similar point when she notes that inexperienced nurses rapidly learn to structure their workload in terms of time-based lists of tasks in their heads. This preoccupation with task/time imperatives is evident very early on in a nurse's career. The investment in the desire of the "new nurse" to be a "good nurse" blinkers her/him to the disempowering and demeaning nature that these tasks symbolise (Walker, 1993). Indeed, as Walker contends, junior nurses often enjoy these tasks in that they believe they are at last doing something useful in the world (p.156). One of the respondents recounted how she had been made an "example" of by a ward sister when she first entered nursing a couple of decades past..

> *When giving out breakfast we had to line up and she (the ward charge nurse) would time you on how long it took you to give out the breakfast, she was a perfectionist. On this particular occasion I took out two "Ws" - Mr Walters and Mr Walter, somebody else came out with another "W" and I had given the wrong tray out. When I came back to the kitchen, we all stood in line getting ticked off and she actually threw a tray with bacon and eggs through the air. Everybody stood there rigid with fear, it only splashed on me and then she said "Get down there and clean it up". So among those feet I was cleaning up all this stuff. And I took that, you know I was destroyed but I did it.*

While this respondent recognised that such blatant abuse of power may not be evident today she went on to say:

> *"...there's a lot, of course, of more recent stuff...things that are destructive to people to their face...".*

Because of the tight scheduling of tasks nurses also march to the drum beat of time. Patient care is conducted within strict task/time grids: there is a time for washing, for eating, for medication, for visitors, for physiotherapy, and so on. The patients' day is constructed within a "linear time" framework.

Time is linear when it is said to be, "sequential and unidirectional, like an arrow speeding away from the taut bowstring that launched it toward its unseen target" (Knudtson and Suzuki,1992: 152). A nurse's work shift is not finished until all assigned tasks are completed. The nurse who fails to complete her/his tasks at the end of a shift is *persona non grata* to oncoming shift-worker colleagues. So powerful is the notion of task/time imperatives in the nurses' psyche that patients are sometimes seen as tasks, not people. Travelbee (1976) suggests patients can be categorised by a process of human reduction. For example, they may be perceived as illnesses - "Have you done the obs on the chole in room 32?" - or as tasks - "I have to do the dressing in room 1". During the course of this study, psychiatric nurses were heard to refer to people as "*PDs*" (personality disorder) and *"schizophrenics"*, thus reducing the individual to the status of an illness or worse still a disease.

Task/time might be said is the lens through which nurses view their work. For instance, one respondent commented that her colleagues constantly griped about the need for doing half hourly observations on their patients (women in labour).

> *About every week someone will say why do we do it, why do we do it?...because the policies and procedures are so ingrained in the culture of the ward that they cannot see ..yet in another setting we just ignored the policies, we just didn't do them. The standing orders book sits on the ward like a bible.*

What the above attests to is a highly developed structural efficiency model operating at the micro level of the hospital organisation. One consequence of striving to meet strict task/time schedules is that nurses themselves become entrapped in them - a nurse who spends "too long" on the medication round may have to forgo a coffee break. These times are often fixed and are not to be "contaminated" by work time, which should not spill over into leisure time. Some years ago when I was a student nurse, I stayed back following my work shift to see how a particular procedure was to be carried out on a patient I was assigned to earlier in the day; however, such interest was frowned upon by the ward charge nurse who informed me that I was off duty and therefore should go home. Another example illustrates nurses' adherence to a strict boundary between work time and non-work time. During the interviews, one respondent remarked how staff on his ward were obsessed with time. He recounted the tale of a colleague who, on being accused by a

fellow colleague of leaving work early was at pains to point out to her clinical nurse manager that the reason she had left work *two minutes* early was because she had to stay on duty a couple of minutes overtime the day previous to the one in question.

Yet, as individuals we can think of our existence in terms of "circular time". Although we all age and we compare the past to the present (linear time), nevertheless we breath and sleep in regular cycles and are surrounded by an environment that revolves around repeated patterns, for instance, the sun rises and sets every 24 hours, deciduous trees lose their leaves every autumn, and so on - circular time. The fact that nurses provide a 24-hour service does not diminish the notion that individual nurses are conditioned to work within a linear time frame. Nurses normally work in shifts of eight hours where tasks are completed in order of priority. It is usually not the case that an individual nurse will deviate from the routines of her own eight hour shift. Should a patient be allowed to stay in bed and have her/his wash in the afternoon, rather than the morning, the on-coming afternoon staff would most likely complain that the morning staff were slack in their work. Therefore, individual autonomy, if it is to be exercised, is normally confined to the boundaries of a nurse's eight-hour shift. Time routines in a hospital are akin to those of organised factory work. Nurses describe their working time as a shift; break times are set with little room for flexibility in relation to what and when tasks are accomplished. Arriving on time for work is as important as leaving on time. Time at work outside shift time is classed as overtime.

As well as the constraints on individual autonomy, often nurses' work rosters militate against nurses getting to know their patients on an on-going basis, thus the care patients receive can be disjointed. Rarely, is one nurse responsible for a patient's total nursing care for more than one or two shifts. Such disconnected nursing care practices not only fragment the individual and the nursing team but cause frustration among patients. Smythe (1984) recounts a patient's complaint: "I've met five nurses today and I still don't know who is looking after me. When I ask one of the nurses for a pain pill, she says she'll have to get the nurse" (p. 224). Usually, nursing rosters are organised in such a way that ensures individual nurses do not have successive shifts with their patients. Primary nursing on the other hand, where one nurse is responsible for the total nursing care of one or a few patients, has the potential for decreasing the fragmentation of care experienced by patients, although it may compound the isolation of individual nurses unless there is a mechanism in place to foster cohesiveness.

Street (1992: 251) makes the point that nurses often work in spaces that are separate from one another When there is an individualistic approach to patient care and when a nurse is allocated a number of patients and a physical space within which to work, (s)he will claim ownership of that space along with the patient care activities performed there. This increases a nurse's isolation and hampers collaboration. Much of current nursing practice fluctuates between task, team, and primary nursing or a mixture of these. Nursing has yet to come to grips with deciding on an acceptable delivery model of care. Where care is disjointed it is difficult to imbue a sense of ownership when things go

wrong and therefore problems go unresolved. A respondent commented on how he had been put into a potentially dangerous situation that had he been properly briefed beforehand he might have been able to handle the situation differently.

> *I came on duty at 9:30 pm and I took the evening handover. The only information I got on this particular patient was" "He's a very strange fellow, you'll know what I mean when you get to meet him" - nothing more.*

It turned out that this particular patient threatened the respondent and his family with physical violence when he didn't accede to his demands for narcotic analgesia. There was no opportunity to discuss the matter with the nurse who handed over this patient the previous evening as she was off duty the following day. Another respondent summed up the situation thus:

> *We are not clear that we are here to give a professional service,*

indicating that her colleagues had a long way to go with respect to improving their relationships with both their patients and with each other. The impression given by respondents is that nurses' work is parcelled out and there is little in the way of on-the-ward staff development that has as its focus the creation of better working relationships and patient-centered care.

Added to the above "isolationist" work practices Smythe (1984) suggests that the dynamics of "victim psychology" operate in the nursing profession. One feature of victim psychology is that lower-status individuals in a hierarchy tend to feel alienated from their peers and instead of offering each other support they pull against each other in backbiting and open competition. "As a group nurses are competitive, but unlike other groups who compete in the outside world for money, status and power, we compete with each other and tend to withhold support from those within our ranks who show signs of succeeding" (Smythe: 227 citing Brooton et al., 1978). One of the respondents referred to this sort of behaviour as the Mexican crab syndrome:

> *You have a bowl of crabs and they climb on top of one another and the one that reaches the top and is just about to climb out, the rest of them grab him and pull him back...,*

- a similar notion to the tall poppy syndrome.

Adherence to a task/time imperative provides the backdrop for situating the occurrence of aggressive acts within a nursing context. While such an adherence may not be the initial cause of aggression, nevertheless, when workers are trapped by the exigencies of their own work practices, when aggression does arise from whatever source, alternative behaviours are proscribed. And the search, if any, for new and productive ways of working and relating is narrowly focussed.

4.4 Clique formation

Another disuniting factor at work is the formation of "cliques". It is in the formal contact at work that individuals establish working relationships, however such relationships are often elaborated upon by various forms of informal contact (Edelmann, 1993). Informally, individuals may form alliances or coalitions with other like-minded individuals. Clique formation at work can be a major factor in fomenting interpersonal difficulties. One of the respondents noted,

> *..that very often nurses form cliques to undermine others, when new to the situation you can easily end up being their target until they know where you stand.*

In the context of midwifery care, a respondent commented on the hostile reactions she and her colleagues faced when they wanted to implement a new work practice designed to offer patients continuity of care. Midwives subscribing to the new scheme were:

> *Continually harassed by the traditionalists. Midwives working in the delivery suite faced aggression ranging from "snide comments to verbal attacks on technique and procedures to refusal to help care for women who were part of the new care scheme.*

Similarly, within a mental health setting, a respondent commented on the factional split among nursing staff.

You either belonged to the "in group" or to the "out group.

The formation of cliques or subgroups can serve several functions. They can act as a powerbase for individuals to gain control, they can resist change imposed from outside, and they can function as a buffer for individuals when they feel threatened. Individuals within cliques can share ideas with people of like minds. It is perhaps inevitable that individuals will want to associate with others with whom they get along, which usually means that they share similar interests and values, anyone seen as a threat to such relationships will be viewed with suspicion and conflict will arise. The midwifery example above illustrates the tensions that can arise when an "out group" instigates new work practices that rock the *status quo* of the "in group". Of course, it would be unwise to speculate too much further here without background knowledge of how these new work practices were developed and introduced to staff prior to the "offsider" group being formed. Most people, even those with high "novelty" needs are discomfited by the process of change because they are removed from the familiarity of what they know and thrust into uncertainty and an unknown future. Therefore, to effect change it is vital that processes are in place to help staff make a smooth transition (Gilles, 1989: 459).

4.5 Nursing as a low-status profession

In accounting for violence among nurses, Smythe (1984), suggests that nursing is a low-status profession within the health care system.

Consequently, nurses may not want to associate with colleagues. They may wish instead to align themselves with groups that are perceived to be of a high status, such as, doctors and hospital administrators. In such an atmosphere, Smythe contends nurses may openly attack fellow nurses. In the context of Social Identity Theory (SIT), individuals strive for positive social identity and membership in a group contributes to this. Evaluation of an individual's own group is based on comparisons with other groups, and a positive social identity (and hence a positive self-esteem) is based on favourable comparisons (Fisher, 1989: 29 citing Tajfel et al., 1971). When inter-group comparisons are unfavourable, as is suggested by Smythe above, ie, nurses see themselves as a group less favourably compared to doctors and others, a negative social identity and dissatisfaction with one's group results. A remark made by one respondent alludes to her negative perception of her own profession compared to medicine :

> *Not nice to say that nurses are a violent group of people...but nurses tend to kick the knees from under you, medics keep it more within the family.*

And another respondent said:

> *A doctor wouldn't do that sort of thing to another doctor, I mean undermining. A doctor wouldn't do it publicly, they may do it within their own group, however I think a nurse might do it and talk about another nurse openly in front of a client.*

Low self-esteem, it is held, results when our evaluative outcomes favour outgroups over the group that one belongs to. Even though in Australia the professional status of nursing is being upgraded through tertiary education programmes at the undergraduate and post-graduate level, nursing here has not yet clearly articulated a career path founded on professional qualifications beyond that of the comprehensive level nurse. It is perhaps not surprising that nurses may look to other professions to ascertain their worth as there are no ready "markers" within their own profession to gauge professional maturity. Without the necessity of formal post-graduate qualifications for advancement in one's career, it is not surprising that the refrain from one respondent -

> *It is not what one knows but who one knows that is important*

- continues to hold sway among many nurses' perceptions regarding promotional opportunities. It is curious to note that while many writers in nursing espouse nursing's virtues in terms of providing a buffer between the patient on the one hand and the impersonal care offered by medicine on the other, nurses, at least, in Australia, are adopting role names and behaviours which are more in keeping with a medical model of care than a nursing one. Ward charge nurses are frequently referred to as clinical nurse *consultants*, and nurse lecturers who maintain field practice refer to themselves as *clinician* lecturers. And the stethoscope, formerly a distinguishing appendage of doctors, is now frequently seen adorning the neck of nurses on and off the ward/unit. While reflecting on these changes a colleague remarked,

Soon, it seems, we'll all be mini doctors.

While individual nurses may complain about their colleagues' behaviour, they complain about the "system" in general too - "not enough authority; too many rules", and so on. Notwithstanding such gripes, Street (1992) suggests that nurses pay lip service to their frustrations, in reality, they want to keep the *status quo* as they value their current roles. The implication here is that nurses, in Australia at least, have not shaken off their subservience to medicine and that name changes discussed above reflect merely a semantic rather than an actual change in behaviour or relationships vis-a-vis medicine.

4.6 Aggression breeds aggression

The notion of the *status quo* is a relevant concept from another perspective too. One respondent told of the *"tit for tat"* reactions that occurred between colleagues. Once aggression arises from whatever source it is likely to be maintained unless remedial action is quickly taken. Several reasons can be advanced for this view. First, one consequence of aggression is to instil anger in those to whom it is directed (Wykes and Whittington, 1994:114) with the result that abrasive relations may be maintained or at least there is likely to be a legacy of a general absence of goodwill between staff. Second, where aggression gets "results" its perpetrator is likely to be reinforced, thus continuing the likelihood for its existence. According to behaviourism, behaviour that is reinforced is likely to be repeated (Skinner, 1953). Third, where aggression is commonplace amongst staff, those new to nursing with

little previous work experience may see aggression as part of the job and indeed may even mimic aggressive behaviour in those whose positions they aspire to. Walker (1994: 116) contends that junior nurses very soon become enmeshed in the hierarchical structures of the organisation or as one respondent from the present study put it,

> *You either shape up or get out.*

Kohnke (1981) suggests that junior nurses are quickly socialised into a culture of nurse-to-nurse abuse. Many hospital-trained nurses can attest to stories of abuse when they were junior nurses. For example, one respondent told of her experience as a student nurse in a general hospital after she had left school in the mid seventies:

> *A lot of the senior staff weren't very nice... you know, all the tutor sisters would line you up and make sure you had white underwear on and all this sort of stuff...because we all lived in the nurses home we'd get out there in the morning and they'd check us....*

Another reported how as a new nurse to a ward she was terrified by a ward sister.

> *She had been in Vietnam and ran the surgical ward like clockwork and she always sized you up. On my first day on the ward as I walked through the door she was waiting at the office and the very instance she saw me she got me by the collar and said I'll show you from now on, nurse, how to*

walk in my ward, and she marched me down the middle of the ward and turned me round and marched me back.

Kohnke (1981), discusses the "generational" nature of abuse in nursing - from the older head nurses to the younger staff. She likens abuse among nurses akin to the circular and generational nature of child abuse. She suggests that abuse occurs when nurse leaders have an attitude of "receiver", ie, those who self-righteously believe that they have earned the right to be served, and because they were treated badly as a junior nurse they see it as their right to do the same to juniors. Halsey (1978) suggests that some nurse managers fall prey to the "queen bee syndrome" (Staines et al., 1974). "Queen bees" are talented individuals who have reached the top of the nursing profession. They identify with other high fliers outside nursing and avoid associating with nurses lower down the nursing hierarchy. They thwart the career aspiration of other nurses while promoting the values of traditionalists regarding the place of women in society - in effect queen bees are antifeminists. In terms of facilitating cohesiveness and colleagueship among nurses at all levels they promote dissatisfaction and resentment. Smythe (1984) suggests "that instead of having a reciprocal, supportive network of peers, we develop pecking orders that dole out stress to those lower in the hierarchy" (p. 228). The concerns raised by many respondents in the present study concurs with this view too.

Finally, in situations such as nursing where one's frustrations at work cannot easily be taken out on patients unhappy staff may react aggressively towards colleagues when there are no other outlets

available for them to vent their feelings. All in all, the potential for the maintenance of aggressive relations between staff is high in health care settings unless strategic action is taken to foster team spirit amongst staff. However, the view of respondents is that nurse managers often fail to take decisive action to lessen the occurrence of aggression in the workplace.

4.7 The "response" of nurse managers

Nursing work is generally run along hierarchical lines. Status is accorded on the basis of "levels" or expertise. All newly qualified nurses begin at level one and many nurses remain at this level throughout their careers. A level-two position, of which there are only a few per ward. is said to denote a higher degree of nursing skills. Most wards/units have one level-three position. This person usually has the title of clinical nurse manager (CNM) and it is (s)he who acts as the interface between nursing management - which is normally divorced from the day-to-day activity of the clinical setting - and "bedside" nursing. The CNM therefore, has a crucial role to play in negotiating between, on the one hand, management's wishes and, on the other hand, the views of the clinical staff. As well as this, the CNM has the onerous task of setting the agenda for staff work practices. The CNM or as in earlier parlance the ward charge nurse, is normally a key figure in developing a ward's or unit's culture (Fretwell, 1980).

Most comments in the present study attested to aggression between colleagues of similar job status, aggression in relation to nurse

managers, ie, top-down aggression - vertical aggression - did not figure much among respondents' concerns except in relation to criticising them for failing to implement supportive structures when aggression did arise or to take appropriate action to prevent its recurrence. It seems managers are blamed for acts of omission rather than acts of commission.

Rarely, it seems, are staff anxieties over aggression addressed in formal debriefing sessions or team meetings. Even following incidents of aggression by patients there is little in the way of a prompt supportive response from management it would seem. Managers might be forgiven for not responding to some incidents on the grounds that they are not always aware of the often subtle and "hidden" forms of aggression that takes place among staff. However, it would be expected that all managers take action following major incidents of aggression faced by staff whether from patients or from colleagues. Sadly, the reports from respondents suggest that managers do not always respond to these incidents either. Two stories illustrate the lack of a management response. One nurse recounted what had happened to her when she worked alone in an evening clinic. Two of her clients began fighting with each other in front of her in her office.

> *The incident escalated with both clients shouting and abusing each other for approximately 40 minutes ... each accusing the other of physical abuse. It eventually ended when the husband stormed out of the office.*

When this respondent was asked what happened after the incident she reported, *"For the clients, rapid counselling was arranged, for me - nothing"*. She rang her manager after the incident to say what had happened and to ask for a relief as she had a number of patients waiting to be seen, but her manager was in a meeting and her call was not answered. The next day she eventually got an apology from her nurse manager after she threw a "tantrum". It appears, no further action was taken by management to try and prevent a similar situation arising in the future or to inquire into the vulnerability of nurses working alone in the evenings in isolated clinics. As far as the respondent is aware, nothing has altered regarding nurses' working conditions in such clinics. The next incident occurred when a doctor attacked a nurse. This illustrates the extent of a manager's inaction when a serious incident happened under her nose. The respondent, who was new to the clinical setting at the time of the occurrence, related what happened when she asked a doctor for directions to the toilet on behalf of her patient, who was waiting prior to being given her treatment of electroconvulsive therapy (ECT). The male doctor said to this nurse:

> *Get her a (bed) pan"*, but because there was no screen available to provide the patient with privacy, the nurse said she'd prefer to take the patient to the toilet. The doctor then, *"Flew at me, he grabbed me by my neck and pushed me into a large glass partition separating the ECT treatment area from the waiting room. Other nurses stepped in to help and then carried on as if nothing had happened. I took the*

patient to the toiled and later had to go off work on workers' compensation.

This nurse was unable to get anyone to act as a witness to the event even though there were nurse supervisors around at the time. The nurse in charge of ECT later stated that she hadn't seen the incident. This conspiracy of silence only broke when, some months later, the nurse was asked to press charges against the doctor. Staff explained that they were trying to get rid of him. The nurse declined to make a statement about the incident. She explained that she was unwilling to help them as they had not supported her immediately following the incident.

Marilyn Lanza (1984a) reported that many assaulted nurses, despite wanting to talk to someone about their experiences, felt unsupported by colleagues and hospital administrators. Many respondents in the current study expressed dissatisfaction with both their nursing leaders and hospital management generally. Bute (1995) made a similar point ten years later when commenting on the findings of a study into violence experienced by social work staff in the U.K. This author points out that there is an overwhelming need for middle and senior managers to be seen as supportive. In this present study, managers failed to take incidents seriously, they lacked sensitivity in responding to individuals involved in violent incidents and they failed to take action to change practice following incidents.

Even when individual managers are not seen as being abusive to them, staff may harbour resentment towards management in general. A bone

of contention for some respondents was the fact that they or their colleagues were employed on short-term contracts. Many respondents felt aggrieved and "used" by this work practice. Respondents felt that they couldn't openly confront their nurse managers about any issue for fear that their contracts would not be renewed. In effect these staff felt "gagged". From respondents' perspective, this work practice was an abuse. Whatever the merits, from a manager's perspective of employing people on short-term contracts might be, it would seem to do little to promote cohesive working conditions. The fact that, according to respondents, another major hospital in the State did not use this employment tactic, served to add fuel to the injustice felt. Anecdotal evidence suggests that staff who feel that they have been treated badly by the "system" to begin with are likely to harbour resentment even after they have gained permanent employment. This point is illustrated in the following respondent's comment.

> *Why should I do anything more than I have to when the bastards treat you so badly in the first place.*

Why are managers so inactive regarding the welfare of their colleagues? In general and across organisations and countries it seems managers do not always give employees the attention they deserve. Cooper (1987) notes "people, the most important resource an organization can possess, should command a great deal of attention from management but frequently do not" (p. 185). In a review by Cavanagh (1991) on the conflict management style of nurses and nurse managers in a hospital setting avoidance was found to be the most commonly used conflict

management strategy, with competition being least favoured. This author notes that in situations where it is unlikely a person's concerns are going to be satisfied it is easier not to raise an issue and thus avoid the tension and stresses associated with confrontation.

Where aggression and disunity amongst staff are rife managers will need to possess high level interpersonal skills to effect reconciliation. In most instances, however, nurse managers have been promoted without having had any formal training in management skills. The career path as it stands at present in Australia, does not require evidence of formal managerial skills as a prerequisite for management advancement in nursing. This is surprising given the highly complex skills required to manage a busy nursing department. The lack of a management focus in nursing mirrors that in the broader Australian economy. A recent report released by the Industry Task Force on Leadership and Management Skills (1995), chaired by David Karpin, indicated that the majority of Australia's managers do not have the education or skill level of those of the major trading nations. While many managers had good technical skills for their particular occupation, the report noted that they lacked increasingly important abilities, such as, communication skills. The report called for greater training for frontline managers - supervisors and section heads because of their key role in the success or failure of enterprises. Perhaps, nursing ought to be making similar noises. Suggestions for how nurse managers may be instrumental in facilitating good staff relations is discussed in detail in the final chapter.

A final reason for the occurrence of aggression can be sought in the tendency for each of us to view our own negative behaviour as a result of

factors beyond our control and another's on account of their personal dispositions.

4.8 *"Nasty"* colleagues

Working alongside "difficult" colleagues poses particular problems in a clinical setting. In our relationships outside work we can pick and choose whom we interact with and those whom we find "difficult" we can "walk away" from. This is not always an option on a ward where rosters and work practices force people to work alongside each other, thereby limiting the element of choice with whom we work. One respondent commented,

> *You can usually walk away from an aggressive patient or relative, working with colleagues there isn't that option.*

The option of distancing the act from the person appears to be more difficult for nurses when the aggression comes from colleagues than from patients. Almost all respondents were willing to accept that patient aggression may be legitimate in the sense that the patient was not himself at the time of the incident, because of his clinical condition or the fact that he was intoxicated. This empathy for patients is neatly illustrated by the comment of the respondent who said,

> *I think it is much easier to cope with aggression when it comes from a client because you got all the mechanisms in place like they are not a real person they are a patient and*

so you know you could label them as behaving like that because of illness and so on and you can rationalise it but when it comes from your peers or from your supervisor then it is very threatening because it threatens your whole career but it is also threatening your place in the team and how people perceive you....

When colleagues were perceived as aggressive there was little in the way of reconciling the reasons for their behaviour other than in terms of the personality of the perpetrator, ie, aggressive nurses were *"nasty people".* When questioned about why colleagues were aggressive one respondent said,

Can't understand it, I'm not nasty.. I can't be nasty... .

Can it be that all of the 29 nurses interviewed were the "good" people, ie, they themselves were never "nasty" to a colleague? Rowett (1986) noted that both assaulted and non-assaulted social workers saw colleagues who had been assaulted as more provocative, incompetent, authoritarian and inexperienced than non-assaulted social workers. Why did these social workers who had themselves been assaulted persist in such negative attributes of assaultees - one would have thought that their own experience of assaults would have invalidated their convictions? Rowett suggests that social workers are socialised during training into believing that only a certain type of individual is assaulted. Even when they are subsequently assaulted and, presumably, recognise that they do not fit the negative stereotype of assaulted social workers,

nevertheless they persist in holding the same negative image of assaulted social workers. Why might this be so? Two reasons are suggested by Rowett. First, the assaulted social workers did not think of their own behaviour as more provocative, authoritarian etc. Second, by tending not to report the incident, they prevented others from testing the rule either. Also, assaulted social workers were at pains to point out that their particular incident was a unique event, ie, not a typical example, thus they were protected on several fronts from acknowledging that they themselves were typical of assaultees.

In a similar way, perhaps, nurses' view of colleagues as "nasty" aggressors can be understood from the perspective that the reporters of the aggression are unlikely to attach blame for the incident on themselves. It is comforting to see ourselves as being in the right and the other in the wrong when incidents occur and to believe that because of the circumstances we had no alternative but to behave out of character. When we do behave aggressively, we label it as passion or assertion. Attribution research on the actor-observer effects suggests that "... there is a pervasive tendency for actors to attribute their actions to situational requirements, whereas observers tend to attribute the same actions to stable personal dispositions" (Jones and Nisbett, 1972 cited in Lippa, 1990: 118). Apart from protecting one's ego, the actor-observer effect may also be a function of other factors too. Jones and Nisbett offer two suggestions. First, we tend to have more information about ourselves than we do of others, therefore we are unlikely to overgeneralize about our own behaviour. In the situation where we have limited information about the other person we may jump to conclusions

too readily on the basis of limited information about the person. Second, people are generally not an object of their own visual field. When we consider our behaviour we tend to focus on the external environment. Others, though, *are* in our perceptual field. They are seen as responsible for their behaviour. They are assessed in terms of their inner attributes or dispositions.

The notion of self-serving bias is relevant in this context also. People are generally disposed to taking credit for their behaviours which result in desirable actions and outcomes. In such situations, one is likely to ascribe inner reasons for one's actions. When the opposite occurs, when our behaviours produce negative evaluations and outcomes we are inclined to blame environmental factors, including other people for our actions - a case of the bad carpenter blaming the tools.

4.9 Conclusion

Conceptually, we have roamed between three levels of explanation of aggression among nurses: a macrolevel; a mesolevel; and a microlevel (Goldstein, 1994). Each of the "levels" helps advance our construction of the reason for aggression in nurses' clinical settings. The macrolevel avoids discussing the details of individual acts of aggression in favour of considering where nursing sits vis-á-vis medicine and other perceived dominant groups and the violence these groups inflict in terms of the denial of power, control and access to rewards - material or otherwise. Nurses it is said, feel alienated and removed from decisions of control and autonomy over their working conditions. Such a frustrating situation

leads to staff-on-staff aggression. The fear of reprisal or because of the fruitlessness of previous attempts to effect change, staff frustrations are manifested as aggression within their own ranks. A couple of respondents alluded to feeling "dominated" by "powerful" medics, however, the thrust of respondents' concerns was not about disempowering medical behaviour but about the more practical concerns in getting along with work colleagues, this does not suggest that nurse theorists have got it wrong about the main causes of horizontal violence, ie, the disempowerment felt by nurses as a result of dominant others. It may be that the present respondents would find it easier to reflect on the wider picture if they were free of the immediate hassles of "difficult" colleagues.

A mesolevel level focus concentrates on the organisational structures, including workplace practices - many of which are controlled by nurses themselves. Nurses often subscribe to work practices that are in themselves disempowering and impedes progress towards change and more productive working relations. Also, there is the idea that aggression within nursing is generational and hierarchical. To effect change, it was argued nurses themselves have first to acknowledge the existence of horizontal violence as a prelude to taking positive steps to address it. It may not be necessary to dismantle prevailing institutional orders to achieve conducive working relations with colleagues and other disciplines. It seems nurses are their own worst enemies. Smythe (1984) and others contend that disunity and enmity among nurses is due to the organisational nature of nurses' work. Nurses subscribe to a disenfranchising work practice model of patient care. Such work

practices may not necessarily be responsible for the occurrence of particular acts of aggression, but given that aggression is perhaps inevitable in all work settings, once aggression or conflict arises, from whatever source, the pressure to conform imposes severe constrains on those seeking alternative and more productive resolutions. Even nurse managers, as we have seen, shy away from getting involved. Thus, the search for work practices that foster good staff relationships is limited. In addition, when individuals do not value their own professional status it is likely that there will be disunity amongst workers. It was suggested above that nurses may not value their own profession with the same status and prestige as doctors do theirs.

The finer-grained analysis provided by the microlevel focus emphasises the interactional nature of an aggressive outburst and goes beyond simplistic notions of aggressors as simply *"nasty pieces of work"* - as suggested by some of the respondents. This interactionist perspective on aggression acknowledges the importance of the person-environment duet - that we shape our environment and are shaped by it. Every incident between two or more individuals is best considered as an interplay of interactional exchanges that feed-off each other (Goldstein, 1994). However, our attributions tend to condition us to believe that when we fight for our rights we are simply being assertive while another's similar behaviour is viewed as aggressive. This view does not deny that in nursing as elsewhere there will be differences among workers with respect to their proclivity to aggress. Every organisation has its pool of "hotheads" and "coolheads". However, it does suggest that it is unlikely that individuals per se are *the* cause of aggression, rather their

aggressive behaviour is better seen as a symptom or a warning that all is not well within their organisational ethos. In the present context, if not this view, the implication is that people who are high on the aggressive stakes are attracted to nursing.

The figure below illustrates the way in which the three levels of explanation for aggression are related to the actuality of aggression within a nursing work culture. While it is perhaps an unremarkable observation that we attribute another's "aggression" on account of their "nasty" personality and explain our own transgressions on account of circumstance, we are likely to retain these perspectives in settings that do not attend to the dynamics of interpersonal relations. Indeed, in nursing, one might suggest that attention to work relationships plays second fiddle to meeting task/time imperatives. Poor role models at senior level and feelings of inferiority about one's work help to compound the issue further, thus ensuring the continuation of conflict, lack of support, clique formation, and an absence of solidarity among nurses at work.

Any urgency to effect change should not diminish awareness of the fact that these responses are from a relatively small number of nurses. Also, we have not discussed the pros and cons of aggression in the workplace nor can we draw comparisons between respondents' views about the level of staff-on-staff aggression and the experience of workers in other settings. It is a consideration of these issues that the next chapter addresses.

Figure 4.8.1 Explanation for Aggressive Acts

CONTENT	LEVELS OF AGGRESSION: Microlevel - Person environment duet	Mesolevel - Organizational impediments	Macrolevel - Oppression theory
Attributional theory, eg, "nasty" colleagues	+	+	+ -
Work culture, eg, disempowering work practices	+ -	+	+ -
Alienation, eg, feeling controlled by the "system/powerful others"	+ -	+ -	+

KEY: The relationship between Levels of Aggression (LA) and Content (C) is represented by a plus and a minus sign. Where there is plus sign only, the LA category immediately above it and the C category immediately to its left are related. A plus and a minus sign together indicates that the LA and C categories may or may not be related.

CHAPTER FIVE

THE PROS AND CONS OF AGGRESSION IN THE WORKPLACE

5.1 Introduction

In Chapter 2 it was argued that aggression can be a positive attribute in many situation when used, eg, for self defence following attack. Therefore to effect a fuller understanding of aggression in the clinical setting we should not lose sight of its possible positive virtues. And for comparative purposes the aggression experience of respondents is judged alongside that of workers in other work settings. The "normality" of respondents' experiences is impossible to judge without such comparative data. Finally, the chapter draws together the main ideas thus far discussed and outlines some of the questions and puzzles remaining to be answered.

5.2 Is conflict between workers necessarily bad?

On one level, no conflict at all between individuals may indicate disinterest and paradoxically may encourage some people to seek conflict to get attention. It might therefore be argued that some conflict is, in fact, to be welcomed for its stimulus function. Conflict (and its behavioural manifestation hostility) might serve some positive effects in that individuals and groups are energised to compete, thereby increasing output and performance, issues are brought into the open, and the best solution wins (Kornhauser, 1965 cited in Argyle and Henderson, 1985).

Johnson (1994) notes that "conflict can be a positive force for nursing if it is used to foster growth-producing change in the profession and in the organisations in which nurses work" (p. 647). However, this is dependent on effective management. Also, conflict can serve group maintenance functions in that it "clears the air" in times of stress, thus preserving the maintenance of relationships (Smythe, 1984: 212; Coser, 1964 after Simmel, 1955; Blake and Mouton, 1961). The evidence from the present study is that staff and managers in the main avoid conflict. Even when serious incidents happen staff debriefing sessions are the exception rather than the rule it seems. A respondent who had previously been in a management position commented:

> *Nurses are not very good at offering counselling even after a job interview ...there are few people out there (nurse colleagues) skilled at handling difficult situations.*

High level interpersonal skills are particularly important in conflict management given the complex chain of events involved in some situations. Coser (1964) notes that Simmel fails to acknowledge the possibility that hostility as a result of conflict may not always be discharged towards the original object of the hostility, but against substitute or displacement objects. When an individual directs her/his behavioural manifestations of conflict against the presumed frustrating object Coser calls this *realistic conflict.* *Nonrealistic conflict,* on the other hand, is when one's hostility is not directly related to a contentious issue and is aimed at tension release of at least one of the antagonists (as in, "mobile hate" after Frenkel-Brunswick, 1952 cited in

Coser, 1964). Coser suggests that realistic conflict ceases when the individual finds more equally satisfying ways in which to achieve her/his ends, whereas nonrealistic conflict is free floating and liable to attach itself to any person that happens to be a "situational target". In reality, Coser acknowledges that admixtures of both "pure" types will be found. The following is an example of how realistic and nonrealistic conflict might interrelate. A nurse, who feels aggrieved because of a changed roster may seek redress through consultation with her union representative (realistic conflict). On being allowed to work her former roster (s)he demands the dismissal of her boss in recompense. In this situation, it can be provisionally supposed that nonrealistic elements, such as, dislike of the person are being expressed by the nurse. The original attempt at redress becomes lost in the struggle for retribution. A similar situation arose during the course of this study where a respondent became so infuriated with what he felt was an unfair workload being foisted upon him by his line manager. The discussion about the details of his work situation were swamped with his preoccupation with listing the manager's faults and his wish for her to resign.

Note too, "that realistic conflict does not necessarily imply that the means adopted are actually adequate for reaching the end in view; the means may merely seem to be adequate to the participants, if only for the reason that they are culturally approved" (Coser, 1964: 54). In Australia, nurses have used strike action in an attempt to secure an increase in salary. In the U.K. at least one nurses' union eschews strike action as a

bargaining ploy. Nonrealistic conflict is said to occur as a result of a person's socialisation process.

From an organisational perspective, nonrealistic conflict may arise when an originally realistic antagonism/dispute is disallowed expression. The first type of conflict, realistic conflict, is seen by protagonists as a means to an end, a means which may change in favour of other means if they appear more favourable in helping them achieve their end. The second (nonrealistic conflict) leaves no such choice, since the aggressive act is both the means and the end, ie, satisfaction is derived from the aggression itself.

In light of the above, organisation that do not allow the expression of worker conflict are in danger of encouraging nonrealistic conflict. Although merely allowing for the expression of conflict may not go far enough. Realistic conflict can turn to nonrealistic conflict when individuals are thwarted in their efforts to reach satisfactory resolutions. Therefore, organisations need to (a) allow free expression of workers' complaints through frank and open discussion and (b) provide the means for workers to achieve satisfactory resolutions. Some respondents intimated that there was little in the way of staff development at ward level which sought to foster worker cohesion. One respondent noted that while junior staff may attend conflict resolution workshops put on by the hospital staff development section,

The people that should be there (managers and other key staff) failed to attend, the people that go are generally those who have less influence in bringing about change.

In the context of on the job relationships, it is hard to see much in the way of benefits for aggressive behaviour apart from alerting one to the fact that all is not well in our relationships. When the line is overstepped say between encouragement and bullying or between assertion and aggression what might have been stimulating at first becomes unwanted stress. In discussing the nature of abuse in organisations Bassman (1992: 59) makes the point that while employers may value flexibility, cooperation and responsiveness in workers they are unlikely to receive these if, when they are not readily forthcoming, employers resort to punishment. Such employer reactions are likely to result in angry compliance. Similarly, relationships among peers are unlikely to flourish whenever disagreements are met with aggression. Some respondents commented how minor suggestions about how the work might be done differently were often met with defensiveness on the part of their colleagues or nurse managers. In effect their comments were taken as a personal criticism and not as an opportunity for sharing ideas. A manager who relies on negative control strategies will concentrate on looking for behaviour to punish. The person who uses positive control will look for behaviour to reinforce. The former seeks to point out another's limitation whereas the latter seeks out strengths. In our society, it seems we are quick to "point the finger". Good behaviour is generally taken for granted whereas mistakes are noticed.

5.3 Costs and benefits of staff-on-staff aggression

Normally, people spend almost a quarter of their adult life at work. The literature to date on work suggests that it is an important factor in one's psychological, social and physical health. One's health may be affected by worry or stress as a result of the organisational aspects of the job or as a result of worry about other work concerns, such as, the fear of chemical or microbiological hazards (Cox and Cox, 1992). The experience of aggression at work can be seen as straddling both organisational aspects and "other work concerns". A nurse may worry about aggressive colleagues and aggressive patients.

Whittington and Wykes (1989) demonstrated that even minor assaults against nurses from patients can have a significant effect on nurses' behaviour. Symptoms consistent with a diagnosis of post-traumatic stress disorder were reported by some of their respondents. Similarly, Lanza (1983) found that nurse victims of patient assault expressed a range of stress-type symptoms. In relation to staff experiencing aggression from their colleagues, many reported a range of emotions and behaviours, including anger, lack of motivation, self doubt, irritability, panic attacks and so on (Adams, 1994). A similar sweep of emotions were expressed by respondents when they recalled their reactions to incidents. The depth of emotion exhibited when relating incidents would seem to indicate that past incidents still featured prominently in their minds and remained a source of distress. Words like *"damage"* and *"burnout"* and the sentiment *"I was totally bastardised by two ward*

sisters" are some examples of the more emotive expressions used by respondents to express their reactions.

Another important factor affecting staff's psychological well-being is the amount of support they receive from their work colleagues. Lack of support can arise when nurse colleagues are present but fail to respond to another's distress. It can also occur when nurses find themselves working alone in remote locations. In such situations staff can be left totally isolated from colleagues and thus worry about their personal safety. As pointed out previously nurses working alone in isolated settings are vulnerable to attack. A respondent recounted how she spent two weeks on her own in an isolated setting without any immediate backup personnel to help when an incident happened.

> *I was furious, ...why are people letting this happen? My colleague had to deal with 28 days of constant mindless violence last year, why are you leaving me here two weeks by myself I thought ... I did have support but it would take at least an hour and a half for people to get here and by that time I could be well and truly history ... .*

Once again, following this incident there was no follow-up call from this nurses' line manager (representing a clear example of passive-indirect aggression). Warr (1992) suggests that low interpersonal support has been found to be associated with high anxiety, emotional exhaustion, job tension, and low job and life satisfaction. On the basis of the present interviews, staff experiencing high levels of colleague aggression might

be expected to show higher stress too, although support outside work may militate against the effects of poor work relationships (Wayment and Peplau, 1995; Norbeck, 1985; Litwak and Szelenyi, 1969).

Thus far, the evidence for the effect of unwanted emotional stress at work indicates dire consequences for an individual's emotional, social and physical health (Jenkins, 1992; Johnson, 1990). For instance, people with psychological disorders have an increased risk of physical illness and mortality, and the risk of death from all causes is twice that in people with severe non-psychotic depression (Sims and Prior, 1978). People experiencing unwanted high stress levels may place a great strain on their relationships with close friends and spouses which may ultimately lead to separation or divorce (Jenkins, 1992).

Not only do individuals suffer as a consequence of poor staff relationships the organisation incurs costs too. In more general terms, unwanted stress may lead to irritability and tensions between individuals and the stressed person may not be able to function adequately at home or at work. At work as at home there may be impaired personal relationships, work performance may be reduced, the person may go off sick or leave, and errors and accidents may increase (Jenkins, 1992). A respondent commented:

> *There's a lot of undercutting, bitching... it's something that really puts me off going back into a hospital to work.*

A respondent in Cox's (1987) study who suffered abuse from a physician commented: " (I) Dread taking care of his patients. Will hide to keep from making rounds with him. He encourages patients to report the nurses and takes delight in it. I avoid answering their call light, and if I do, make my contact as brief as possible. I quit. I began maternity leave, I left nursing altogether". Similarly, respondents in the present study voiced the concern they had of working with certain staff who were "bullies". At the same time, there may be added burden on those staff who remain, particularly if they have to cover for those who have left or have to work with new and inexperienced staff. The pay-off from staff development programmes from initiatives to improve efficiency and so on may come to nought if individuals return to hostile environments.

The dollar costs incurred in recruiting replacements for those that leave or go off sick following aggressive incidents can be large. Costs may also arise as a direct result of workers' compensation claims. Cox (1987), reporting on a study in Texas, concluded that about 18 percent of staff turnover rates were related to verbal abuse. Further, of those who left, some had contemplated leaving nursing altogether. It is estimated that stress, although accounting for only four percent of workers' compensation claims, amounts to 18 percent of all costs of claims in Australia (Comcare Australia, 1993). Conflict with peers or supervisors represented 13 percent of all stress claims. However, this is likely to be an underestimate. Assaults in general are underreported (Lion et al., 1981; Lanza and Milner, 1989) and similarly, intra-staff aggression is largely an "undiscussable" (Ryan and Oestreich, 1991 after Argyris, 1986). Incidents of colleague abuse are likely to remain hidden when

staff fear repercussions. This is particularly likely when managers are abusive to workers lower down the hierarchy. Ryan and Oestreich (1991) report that at least 70 percent of the 260 people they interviewed said that they hesitated to speak up about their managers' abuse towards them because they feared some type of repercussion. Also staff may feel that they may be overreacting to events or as one respondent mused,

> *Am I being supersensitive to this thing (ie, aggression among colleagues)?* Another suggested,
>
> *There's a sense of martyrdom among some nurses.*

Staff may feel that it is futile to report incidents. One of the respondents reported a nurse manager for intimidation, however, the local personnel officer told the respondent to *"Join the queue"* as he pointed to a stack of previous complaints lodged against this particular nurse manager. The respondent was not offered any further opportunity to air his grievance. Unless decisive action is taken when incidents are reported staff are likely to lose faith in the system. Other reasons for why incidents go unreported were raised in Chapter 2 (eg, too time-consuming, suppression of reactions). Many of these will be relevant for colleague abuse too.

5.4 Keeping it in perspective: aggression in nursing compared to other work situations.

Edelmann (1993) makes the point that interpersonal conflicts at work are inevitable in most work settings. Both men and women cite work as the location in which feelings of anger and hostility are most often experienced. Each sex reports experiencing similar levels of aggression (Johnson, 1990: 141). Thus, it is likely that all disciplines and professions whether they be male or female dominated, single-sex or mixed-sex occupations, dominant or dominated are subject to internal conflict. It is unlikely that conflict among nurses would disappear - although it may be lessened - if the chains of the alleged oppression were cut. Even within dominant groups, it seems, conflicts arise. Of course, this is not to suggest that high levels of staff-to-staff conflict are inevitable within working environments. Anecdotal evidence points to the fact that there are major differences between and within disciplines/professional groups with respect to expressed hostility among workers. In nursing, the "atmosphere" on wards can vary widely.

Thomas (1976) reports that middle - and high - level managers spend up to 20 percent of their time dealing with some form of conflict. In a survey by Kaplan and Cowen (1981) industrial foremen spent on average 2.5 hours per week attending to moderate or serious problems of their subordinates. The most common work-related problems were job dissatisfaction and difficulties with colleagues. As many as 48 percent of industrial employees experience role conflict of some kind. Foremen also dealt with a large number of personal problems, such as, difficulties over

drugs and alcohol, problems with children and marriage and sexual difficulties. Incidentally, this latter point emphasises the importance of considering factors outside the work situation that can impinge on a worker's relationships with colleagues.

The number of respondents complaining about a subtle and sometimes not so subtle culture of continuous undermining of their work was a particularly disquieting finding in this study. Some of the university-based and clinically-based respondents alluded to deep feelings of personal vulnerability as a result of *"difficult"* colleagues as the following respondent's account illustrates.

> Interviewer: *"So in terms of compromising your personal safety and self esteem it sounds as if you are suggesting that the greatest threat comes from colleagues."*
> Respondent: *"Oh, for sure. Personal safety not so much, but certainly your (self) esteem. I feel quite vulnerable at times...".*

Adams (1994: 153), points out that bullying at work is only just beginning to be recognised as a significant factor in workplace stress. Adams suggests that in hostile and frightened organisation it is not surprising that the worst side of individuals is brought to the fore. She cautions organisations to be careful lest they be seen as condoning aggression among workers when they subscribe to the notion that problematic relationships in the workplace are inevitable. In discussion with respondents, managers frequently did not take appropriate action when

incidents arose, nor were they viewed as being proactive in taking preventive action to lessen its occurrence.

5.5 Conclusion

The expression of aggression or conflict among staff may be seen as a potential vehicle for bringing issues out into the open, however, unless those involved in incidents have high level interpersonal skills what may have started as a "realistic" concern is likely to degenerate into on-going staff squabbles. All aggression, like other unwanted emotional stress at work can have lasting psychological, social and physical effects on the individual. The organization may also suffer financial loss, reduction in efficiency and "customer" satisfaction. Although it was pointed out that all organisations have a degree of conflict amongst staff, the present findings appear to point to a disturbingly high level of conflict as in worker-on-worker aggression. If the views of these respondents are an indication of what is "out there" it would seem likely that nurse managers will have the added reality of burnout (Freudenberger and North, 1985) The present accounts suggest that nursing not only has particularly high levels of aggression but that there are few signs of management initiatives to redress the issue. Thus, it is hard to see much in the way of aggression being a positive attribute in the present context.

5.6 Conclusion: Phase 1

The findings from Phase 1 allude to a high degree of dissatisfaction among the interviewees with their working relationships as a result of

staff-on-staff aggression and conflict. The vast majority of the aggression described was non-physical, although there were a few reports of physical intimidation and direct physical assault. The aggression from their colleagues (mainly other nurses) was felt to be more problematic for respondents than that emanating from patients and others. The innuendo, put downs, sniping etc, are more damaging, according to respondents, to their psyche than even the physical abuse they sometimes have to face from patients. Professional terrorism was considered an apt concept to subsume these attacks under. Nurse managers were severely critized for not taking a more active role in responding to staff needs following incidents or for establishing protocols to deal with staff conflict. Sadly, the school of hard knocks appears to be alive and well in nursing.

5.6.1 Theoretical insights

Much of the aggression meted out by colleagues could be conceptualized along the lines suggested by Buss (1961). Buss's typology of aggression spanned three dimensions: physical-verbal; active-passive; and direct-indirect (which includes non-verbal aspects of aggression). Accordingly, aggression can be defined thus: to deliberately cause psychological or physical harm to another through verbal and non-verbal acts. Such acts may be direct or indirect and be active or passive. This definition is almost exclusively reserved for nurse colleagues. Patients were in many instances excused for their aggressive behaviour on account of factors (ie, illnesses) outside their control. When nurse colleagues were thought of as aggressive their

aggression was described as an attribute of the person's personality, as in *"nastiness"*. More practically, one can think of most of the acts thus far reported as colleagues breaking *relationship rules* at work, where personal enmity interfered with nurses' ability to get on with the job in hand. Several factors were suggested as being responsible for the aggression occurring including macrolevel, mesolevel and microlevel explanations (p.118). Finally, the costs and benefits of interpersonal conflict were discussed.

From the foregoing the following propositions can be advanced:

1. At work nurses are more concerned about aggression from nurse colleagues than aggression from patients;
2. Staff-on-staff aggression is common in many different clinical settings;
3. Aggression from nurse colleagues is more emotionally upsetting for nurses than aggression from patients or others;
4. Aggression from colleagues is a major work distress factor for nurses;
5. The major forms of aggression among staff are: verbal-active-direct (as in rudeness), verbal-active-indirect (as in gossip), verbal-passive-direct (as in others refusing to speak to you), verbal-passive-indirect (as in others failing to speak up for you in your absence);
6. Both female and male nurses report broadly similar views;
7. Aggression amongst staff goes unchecked by nurse managers;
8. Nurse managers generally avoid becoming involved following incidents of staff or patient aggression;

9. Staff-on-staff aggression in nursing is particularly high compared to other work settings;
10. Several factors are implicated for the occurrence of staff aggression, viz: macrolevel, mesolevel and microlevel considerations;
11. Aggression among staff may have positive outcomes if managed appropriately;
12. Aggression amongst staff impacts negatively on those involved, the organisation, and ultimately the patient;
13. Aggression, once begun, tends to recur;
14. Staff including nurse managers have generally poor conflict management skills;
15. Change in workplace aggression will most fruitfully occur through attention to the mesolevel and microlevel impediments.

5.6.2 The case for a larger sample

While the present study has unearthed rich accounts of individual incidents of aggression and has provided much room for conceptualization, nevertheless many of these notions have to remain tentative. At one level, it can be argued that the views of 29 are enough to warrant concern regardless of their perceived representativeness. Certainly, their accounts are disquieting. Some related tales of severe aggression and most spoke of an on-going atmosphere of undermining of peoples' personal worth. And some respondents were speaking of both the local and national work scene as they had worked in hospitals in different parts of Australia. However, on

a wider front, attempts to fend off cries of scandal-mongering may be difficult to sustain without the benefit of a larger sample. It is easy to accuse researchers who use small convenience samples of being "cornered" by those with an axe to grind. Therefore, the question is begged, do the few represent the many? Also, because the data above has been collected retrospectively it is difficult to demonstrate cause and effect relationships. In an attempt to overcome some of these criticisms Phase 2 was undertaken.

Phase 2 addresses two main issues. First, it assesses to what extent the descriptive accounts about the nature and extent of aggression are borne out by a larger sample. Many of the propositions outlined above are examined to see if they apply to a larger sample. (Note, due to time and space limitations it will not be possible to include all the propositions outlined above for further analysis.) For instance, the following questions are asked: are nurses more concerned about aggression from nurse colleagues than aggression from patients, doctors and others?; is staff-on-staff aggression common in different clinical work setting?; is aggression from nurse colleagues more emotionally upsetting than aggression from patients or others?; and so forth.

Second, Phase 2 attempts to offer an explanation for staff-on-staff aggression. Again some of the propositions outlined above are tested. The idea that aggression once begun is self-perpetuating is further explored. Also, a conundrum requires scrutiny. Respondents' comments suggest that aggression occurs mainly between colleagues of similar grade or level (nurse managers were implicated mainly on account of

their inaction when incidents arose). Nurse theorists talk about the generational *and* the top-down nature of aggression, ie, from the senior to the most junior grade. Is it that aggression is given and received in an indiscriminate fashion regardless of the hierarchical position of the giver or receiver? It is these sorts of questions and puzzles that Phase 2 attempts to answer. A fuller discussion surrounding the areas for investigation at Phase 2 is provided in Chapter 7 and in the relevant proceeding chapters.

Before turning to Phase 2 the merits to be achieved in combining Phase 1, which is essentially an interpretive study, with Phase 2 - a quantitative study - are explored. This is in light of the current and, it would appear, the increasing opposition by some nurse academics (for instance, Emden and Young, 1987; Walker, 1993) to the notion that the traditional scientific methods are unsuitable for deriving knowledge of essentially social constructions and events. However, all research traditions can be criticised for failing to do justice to social phenomena. It is therefore incumbent upon nurse researchers to be aware of the relative merits of differing approaches. The next chapter provides an account on how different research methodologies can be profitability combined in the present study.

CHAPTER SIX

METHODOLOGICAL RAPPROCHEMENT

6.1 Introduction

This chapter provides a rationale for combining qualitative and quantitative analyses in the same study. It discusses some of the epistemological concerns related to different research approaches. Archer and Browne (1989) note than in studies on aggression there is the tension between, on the one hand, the attempt to produce a "harder" science, ie, one based on where variables are controlled experimentally in order to elucidate causal relationships but by doing so dislocate aggression from its social context and, on the other hand, the attempt to study aggression in its social context but by doing so limit the conclusions about cause and effect relationships (p. 261). In the present study, it is argued that the insights from two distinct methodologies are necessary to arrive at a comprehensive understanding of the nature and extent of aggression in nursing and to elucidate cause and effect relationships among variables.

6.2 The pros and cons of a positivistic/scientific perspective

Henry Ford (1919) said "history is bunk", and so too it seems is science according to some post-modernists (eg, Foucault, 1971; Lyotard, 1984) who not only question, but in some cases dismiss, traditional science (positivism) as the repository of truth, at least, for understanding the

social and psychological determinants of people. Essentially, "the post modernists are attempting to challenge traditional scientific assumptions about the nature of truth, objectivity, rationality, reality, and intellectual quality" (Searle, 1993).

Post-modernism is the wholesale rejection that the traditional scientific methods can provide a coherent overall account of society. It suggests that the distinctions between academic disciplines, such as, for instance, philosophy, sociology and literary criticism and between these and literature are crumbling (Cuff et al., 1992). Positivism, on the other hand, clings to the notion that traditional scientific methods are applicable to social research; that it is possible to reach conclusions about the nature of human behaviour through quantification and experiment. It is worth noting that like the term post-modernism, positivism, as espoused in conceptions of traditional science, is a catch all term; within each there are subsumed many shades of differences. For instance, experimental design is far removed from phenomenology, whereas some quantitative descriptive studies are close to ethnoscience designs (Field and Morse, 1985). In discussing the differences between the two approaches, generalisations are inevitable. As noted above, the lines of demarcation between traditional science and post-modernists become unclear the closer we move in from the extremes of each viewpoint.

In traditional science, clarity of argument and rigour in method are the cornerstones by which truth is believed to be found. The scientific researcher is conditioned to be meticulous over matters concerning

evidence, logic, and proof. The results of a study, no matter how appealing they may be, do not lend it credibility; it is the process by which results are arrived at that determines the acceptability of the "evidence". If the researcher cannot demonstrate clearly the efforts taken in overcoming threats to reliability and validity her/his research results will be treated with scepticism. Intuition, if it is acknowledged at all, plays second fiddle to matters of design, methodology, and data analysis (yet, hypotheses and hunches are frequently founded on intuition).

Traditional science sets out to uncover realities that exist independently of the actors present. It allows nature the maximum opportunity to reveal itself to us, as Cuff et al. (1992: 207) succinctly put it. Searle (1993) refers to our common notions of science as "the Western Rationalistic Tradition" (WRT). Although there will be variants of this tradition, Searle suggests that most practising scientists simply take it for granted that the aim of science is to arrive at a set of theories that are true because they more or less correspond to an independent existing reality. Searle (1994), suggests that the WRT can be seen as representing the following six basic propositions: (1) *reality exists independently of human representation.* This refers to the notion of realism, ie, regardless of our ability to speak and think about the world in which we live, there is a world "out there" independent of our representation of it. Consistent with this idea is the fact that much of peoples' existence is socially constructed, for instance, class, status, money, marriage, aggression, and so on would not exist if there were no people alive. And just as these constructs are wedded to human agency, one can cite many

examples of our representations that exist independently of human agency, for example, the colour of the sky; (2) *At least one of the functions of language is to communicate meanings from speakers to hearers, and sometimes those meanings enable the communication to refer to objects and states of affairs in the world that exist independently of language.* Here Searle, suggests that language allows both the speaker and hearer to share thoughts and ideas, refer to objects and on some occasions at least, allows both parties to share realities independent of both. Searle accepts that my idea of a thing, an event, etc. once communicated through language to another person will be conceptualised in that other person's mind such that it mirrors my representation of the thing, event, etc; (3) *Truth is a matter of the accuracy of representation.* Statements are true to the extent that they correspond to realities independent of the actors. And "facts" are defined as whatever it is that makes a statement true (p 65). For instance, the statement, "Fred hit Harry " is true if in fact Fred did hit Harry. The truth of a statement lies in its ability to represent accurately some feature of reality, which is normally said to exist independently of language. Note, however, that "facts" do not always refer to a class of complicated objects or things, to say that a pen cannot swear is as much a "fact" as saying Fred hit Harry; "facts" are defined by whatever it is that makes them true; (4) *Knowledge is objective.* By this Searle means that regardless of the motives of the investigator, be they benign or malevolent, if theories are accurately posited so that they represent an independently existing reality, their claim to truth can be determined irrespective of considerations as to the legitimacy of the researcher. Searle is arguing for the notion of an objective truth. He suggests that if

there are no criteria for assessing claims of truth or falsity we may as well be concerned with the motives of the maker of the claim; (5) *Logic and rationality are formal.* The WRT's notions of truth, logic, reason, evidence, proof and so on, do not by themselves direct one's beliefs or actions, ie, they do not make substantive claims. Logic only says that such and such is the case given that your assumptions are true. Notions of proof, validity and reasonableness stem from logic and rationality. Rationality is said to be a given, therefore, it is not amenable to "refutation" as it does not make any claims to refute; (6) The above five claims have the following consequence according to Searle - *Intellectual standards are not up for grabs. There are both objectively and a valid criteria of intellectual achievement and excellence* - The WRT argues that intellectual products can be objectively assessed by subscribing to criteria that judge the relative merits of statements, theories, interpretations and so on. Objective criteria in this sense refer to the application of standards of merit which are independent of the sensibilities of the people applying the criteria. Searle gives the example of assessing validity in propositional calculus as an instance of objectivity in this sense. It is also accepted that sometimes intersubjective elements will be required to assess the value of intellectual products, such as in the case of historical accounts. In many instances there are no sharp dividing lines between the two. What matters, according to the WRT is that there are rational standards for assessing intellectual quality.

In support of the Western Rationalistic Tradition, Karl Popper (1979) argues that we cannot make inductive decisions "in the sense that we

start with observations and try to derive our theories from them .....that at no stage in scientific development do we begin without something in the nature of a theory, such as, a hypothesis, or a prejudice ....which in some way guides our observations" (p. 19). And more obviously, researchers who conduct observation in the field, may be forced to record one occurrence in preference to another for the simple fact that there is so much occurring at once, and it would be a physical impossibility to record all that is happening at a given point in time. If Popper's views are to be accepted, at least on the basis that it would be difficult if not perhaps, impossible to prove the case otherwise - how could one tell that a given observation was not influenced by one's particular preference? Where does this leave researchers in their desire to be objective? For Popper, such concerns are not that important; for him, it is irrelevant from the point of view of science, whether we have obtained our theories by induction or by merely stepping over them, for Popper the question, "How did you first *find* your theory?" relates to merely a private matter, as opposed to the question, "How did you *test* your theory?" which alone is scientifically relevant.

The concept of "theory" is fundamental to positivistic research. Positivism stresses the importance of making generalisations (theories) that are amenable to verification/refutation; it is the possibility of such that allows the scientific researcher to choose one theory over another; theories are judged correct so long as they resist attempts at refutation. Theories that are posed that do not allow the possibility of being refuted are not amenable to scientific evaluation and by default are seen as pseudo science. For instance, to say that nurses will strike for more pay or that

Harry will hit Fred are irrefutable unless a time limit is provided by which either of the "strikes" will occur. Popper, like Searle, is suggesting the neutrality of the scientific method, ie, procedures are in place which give objective results regardless of the particular beliefs or political orientation of the scientist. To be scientific, it seems, one must show that one's theory is amenable to verification/refutation, and that safeguards are in place to deflect claims that the study is unreliable or invalid because of poor research design - in other words "seeing is believing", ie, the facts speak for themselves. We seek "evidence" (truth) in the study itself, information about the researcher and her or his biases are not relevant to determining the worth of a study, so it is assumed. But these claims for traditional science are not without criticism.

Support for distancing science from claims of it being *the* arbitrator over matters of "evidence" and "proof" has come from Thomas Kuhn (1970). He suggests that science is subject to prevailing social interests. Scientists are not operating as it were in isolation from their sister or fellow scientists in attempts to produce "objective" knowledge. Scientists are part of a privileged community which is subject to custom and precedent and which sustains and maintains a conception of what is and is not legitimate knowledge. The claim that knowledge is "outside" the self interest of a community of scientists is called into question by Kuhn. Theories that are resistant to refutation are no more "sound" than any other theories "since it is never fully clear whether some observed state of affairs should count as a refutation.....and reasonable men disagree on the importance of problem-solving success, explanatory success, resistance to refutation and so forth" (Barnes, 1985: 93). Kuhn rejects the

idea that science necessarily fosters open-mindedness and flexibility and the idea that traditional rationalistic standards are attainable. Also, he refuses to accept the notion of truth as being independent of prevailing social realities. In similar vein Hanson (1962) suggests that scientists are "theory laden", they are not dispassionate observers of the world. Although it should be pointed out that Kuhn's remarks are not to be taken as a repudiation of traditional science, Kuhn's "Structure of Scientific Revolution" can be seen as edifying science's great achievement down the ages. What Kuhn is attacking is the notion of rationality as outlined say by commentators like Searle which suggests that the production of knowledge is the result of universal reason and logical articulation of individual scientists. Kuhn's account suggests that the scientific paradigm as espoused by Popper is too simplistic and too narrow for a comprehensive understanding of scientific knowledge. Kuhn appears to be suggesting that what counts as acceptable "knowing" is relativistic to an extent, he writes, "scientific knowledge, like language is the property of a group or else nothing at all" (Kuhn, 1970: 210), science then is a social practice. Kuhn is not undermining the viability of science to progress, or that science is not rational. Indeed, as alluded to above, Kuhn is a committed admirer of the scientific process. What Kuhn seems to be suggesting is the relativity inherent in choosing new research paradigms when the current paradigm fails to account for anomalous results. The choice then becomes the preserve of the scientific community and scientists have to choose not on the basis of some a priori arbitrator but rather on the basis that one paradigm holds out more promise for solving problems and to an extent appears more aesthetically pleasing in its conception of how pressing problems may be

solved. Kuhn remarks that "the competition between paradigms is not the sort of battle that can be resolved by proofs" (Kuhn 1970: 148). Looked at from this view, traditional science does not possess a foolproof "bias detector".

Two concrete examples are given which illustrate the problems of accepting science's claim to "pure" knowledge. Keller (1991) cites the case that virtually all of the animal research on rats has been performed on male rats. Female rats have been excluded because they have a four-day cycle that complicates experiments. The implicit assumption here is that male rats are representative of the species. The closer we move towards a social science the greater the possibility of bias. This is perhaps not surprising given the fuzziness of many of the concepts we use and the difficulty in determining suitable yardsticks for measurement. Even in social surveys, the sociological paragon of the virtues of positivistic method (Cuff et al.,1992: 204), problems of bias are noted. Grichting and Caltabiano (1986) demonstrate the potential bias inherent in survey interviewing. In their study, subjects changed their attitudes following the interview, indicating that attitude change in survey interviewing may be a function of the interview process itself. And, leaving aside for a moment the inherent bias in procedures, the idea that scientists are nevertheless impartial purveyors of their craft is not without criticism either. The case of the forged IQ results by Sir Cyril Burt is a dramatic and telling indictment of how science can be misled by scientists who want to serve their vested interests. Science, like any other "collective" is not above dangers of succumbing to self-interest and bias.

Other criticisms of positivism's empirical stance point to its reductionist approach to knowledge. By this is meant traditional science is more suited to the exploration of natural phenomena, such as, plants, metals, gases, etc., whereby experiments can be controlled so that theories can be tested and laws determined; adopting principles of natural science to study people limits what is amenable to study. Understanding of complex phenomena such as, for instance, the experiences of a person following an assault, is not subject, at least on ethical grounds, to controlled experimental manipulation. In the "aggression" literature recall that the majority of ideas about the nature of aggression have been conceptualised by individual scientists and rarely have their theories been subjected to empirical investigation outside the laboratory situation. Positivism, it is suggested by its critics, does not offer an adequate or even a relevant model for the social disciplines. It is argued that the investigation of natural phenomena requires a distinctly different approach to the exploration of human behaviour; the idea that natural and social phenomena can share the same deductive model is said to be misconceived.

6.3 The pros and cons of an alternative perspective to scientific notions of knowledge

It is suggested that we need to devise new and imaginative ways to determine knowledge of social life. What is required is the development of a hermeneutic approach to the study of human action that acknowledges the importance of the individual's perspective. Travelling further along the anti-positivist's road one encounters such iconoclasts

as Dilthey, Collingwood, Wittgenstein, Gadamer, Kuhn, Rorty, Feyerabend, and Derrida, to name a few, who together reject positivism as a suitable method for the social science (Skinner, 1990: 6-7). And at the extremes of the anti-positivism continuum it is suggested that we can never, with any certainty, know if a given interpretation is correct. If this is so, then we have no way of choosing one interpretation over another, indeed, the more interpretations there are of the same situation the more we have to conclude that the whole business of interpretation, and by implication knowledge generation, is a fruitless endeavour (Derrida, 1981). Thus we cannot know anything apart from knowing this fact! Of course, this contention relies on accepting that Derrida has a monopoly on deciding the canons by which knowledge is generated.

Within nursing, similar unrest is evident about which research methods are appropriate. Nurse scholars that have moved away from traditional scientific methods have often met with defensive responses by those imbedded within a positivistic paradigm (Street, 1992: 69). From an inspection of current journal articles it would appear that an increasing number of nurse scholars subscribe to the idea of the essentially unknowability of phenomena and disavow the relevance of traditional scientific methods (eg, Walker, 1994; Emden and Young, 1992; Bruni, 1989). Meleis (in Street, 1992: 70) argues that nurse scholars are now challenging the old paradigms of knowledge and are shifting towards a concern for: "humanism, holism, the incorporation of sociocultural content, perceptions of subjects of research, subjects and researchers collaborating in the research process and a qualitative approach, and so

on. Sandelowski (1993) quotes Tesch (1990: 304) to make the case that qualitative research is much like art:

> A representation in the same sense that an artist can, with a few strokes of the pen, create an image of a face that we would recognise if we saw the original in a crowd. The details are lacking, but a good "reduction" not only selects and emphasises the essential features, it retains the vividness of the personality in the rendition of the face.

Similarly, according to Sandelowski, good qualitative research grabs the essence of the phenomena. But it is not clear just what is meant by such a remark. With the art example cited one can judge the merit of the picture alongside the face it purports to represent. Unfortunately Sandelowski does not elaborate on the yardstick by which we can judge her notion of "good" qualitative research when there is no face available - to use the painting analogy - with which to compare. However, if she was to propose a yardstick she would have to avoid specifying "objective" criteria like reliability and validity; otherwise, her thesis that positivistic notions are not relevant for qualitative research would collapse.

What Sandelowski and other nurse academics who in unison with many anti-positivists leave us with is the idea that interpretation is an individualistic process, that there is, to quote an art example, "no one correct way to draw a face" (Tesch 1990: 305). To look for "truth" in terms of the methodological steps taken by the researcher is folly. The

instrument by which the respondent's world is brought to light it is argued, is a function of a complex interaction between researcher and subject(s) which is dependent on among other things, the rapport qualities of the researcher and her/his creative insight. Stated like this, how would it be possible to lay bare intuition and achieve the notion of methodological monism - ie, the unity of scientific investigations regardless of the subject matter under investigation (Von Wright, 1979: 12)?

Further, if it is proposed that there are different versions of "correctness", as implied above, it seems pointless to argue over which version is *the* correct one - presumably they all are is the simple answer. Contrast this view with that of traditional science which insists that "truth" can be assessed with reference to the transparency of the study's methodological steps.

Hoy (1985: 51), suggests that whereas epistemology (the methods and procedures of traditional science) searches for a privileged standpoint as the guarantee of certainty, hermeneutics maintains there is no uniquely privileged standpoint for understanding. This fundamental cleavage between traditional science and post-modernists illustrates some of the points of tension arising at each end of the positivist-post modernist dichotomy. Guba and Lincoln (1989) leave few doubts that there is no possibility of rapprochement between these two camps simply because the ontological and epistemological assumptions of the two views are incompatible.

Similar heated debates have arisen in psychology between behaviourists and psychoanalysts as both perspectives offer strikingly contrasting notions about the cause and treatment of mental disorder. For the diehard Freudian or Skinnerian therapist a "middle ground' would not be an option. Their argument might run thus: it is not possible to combine such contrasting notions to arrive at a new form of treatment based on a watered down version of each approach. The differences are too fundamental for this to be a reality. It would be hard to imagine a behavioural approach used for treatment at the same time as a psychoanalytic one - if the patient didn't come out of treatment more troubled than (s)he went in, the psychologist would! Likewise, in research, diehards from each side of the debate, might say that it is foolhardy to think that a researcher can somehow fuse the best of both paradigms or engage in a dialogue between the two sides of debate. Data collected for interpretation as part of an overall quantitative design are no more subject to the rigours of quantification as data obtained in a purely qualitative research project. Interpretative data are interpretative data regardless of the context from which they arise. Interpretation, as we have seen, is founded on the belief that the researcher is at one and the same time both judge and jury of the worth of what is produced as "evidence", unlike in positivistic research "evidence" is said to be given to a study on the basis of its conformation to previously stated rules of research conduct.

6.4 The case for a middle-way

Does this mean that there is no such thing as a "middle way" in other words, that there is a incommensurability (Kuhn, 1970; Jackson and Carter, 1991) among research paradigms? For the post-modernist, the claim that (s)he is "subjective" would be treated as a compliment, whereas for the traditional scientist such a remark would be derided. To argue for one or the other approach is pointless in the present debate - philosophers of science are still hotly debating the issue.

It is important to recall that both positivists and post-modernists are each subject to criticism (note however that such criticism is not in any way to be seen as arising from some fundamental neutral principle by which claims to knowledge can be evaluated). For those qualitative researchers who worry about validity and reliability as per traditional science and for those positivists who are concerned about the utility of statistics adequately to represent their data the notion of something akin to a "middle ground" is adopted. Willmott (1993) in arguing for paradigm commensurability suggests that

> an openness to the other does not necessarily result in subordination or the suppression of difference. Such an engagement can provide a useful abrasive upon which to sharpen one's blade without necessarily stimulating or satisfying a desire to plunge it into one's adversary.

Indeed, it can be difficult to proceed with some studies without recourse to both research traditions. In the same way, claims of "eclecticism" by therapists are not to be dismissed either. For instance, there is little to stop a therapist experimenting with different therapies sequentially as opposed to simultaneously for a given disorder. Also, (s)he may want to experiment with different approaches for different patients. And, unlike the stark choice facing therapists described above, it may be possible to fuse some aspects of competing theories. Over the past few years an increasingly popular treatment for mental disorders is described as cognitive-behaviour therapy, where the contribution of patients' cognitions in the production of disorders is acknowledged alongside the recognition of situational determinants of behaviour. At any rate, it is presumptuous to argue that one can only be an "either or", ie, a post-modernist or a positivist; cannot one be something else besides? Code (1991: 320), in the context of a feminist critique of traditional science, proffers an olive branch in the form of "mitigated relativism" when she urges for a "middle ground" perspective, one that acknowledges the inherent relativism in the social sciences. However, claims for a synthesis between contrasting epistemologies are unlikely to yield much support, except perhaps, from an ideologically inspired adherence, without a corresponding outline of how a rapprochement might be accomplished. With any study, the slogan "buyer beware" is appropriate advice regardless of the banner under which the researcher flies. How we label what we do together with the claims we make for our research is of minor importance compared to how we describe what it is we do. If we want to be convincing in our argument it is imperative that we clearly state the basis upon which we ask others to "buy" our ideas.

In the present study, insights gained from an interpretative study were assessed to see if they were in fact relevant for a larger number of respondents. It was felt important to ask a larger sample for their views in order to rebuff claims that the findings of the qualitative study were founded on a "hand-picked" sample, thus making it easier for others to dismiss the study's findings. In light of the findings thus far, it might be anticipated that there would be many defensive reactions to them.

In the previous chapter, respondents were at pains to point out the difficulties they had working alongside some of their colleagues. Even in situations where aggression from patients has traditionally been high it was staff difficulties that were uppermost in respondents' minds. However, it is impossible at this stage to be certain of the extent of the problem for the "average" nurse without first ascertaining the views of many more nurses in different work settings. While the results of Phase 1 allow us to report detailed descriptions on the few as well as affording us the opportunity to speculate about what might be "out there", it is difficult to move beyond these particular findings and offer a general comment about the overall nature and extent of aggression in nurses' clinical work settings in Northern Tasmania. Nor are we in a position to test cause and effect relationships among variables.

Providing we obtain a reasonable return rate from our survey, or at least secure a large convenience sample of respondents who are alike other nurses on important variables, we are in a much stronger position to advance our views about the extent of nurses' aggressiveness. And if the results here are in accord with what nurses said during the

unstructured interviews we can be fairly confident of our findings. We can also suggest what are "extreme cases". In the interviews with nurse colleagues, one of them related the tale when her friend had her car wheels tampered with after she had "dobbed in" on her colleagues' rough treatment of patients - hardly a typical case one might say - but difficult to suggest otherwise without first ascertaining the views of many more nurses.

The interpretative mode provides us with accounts from the respondents' own perspectives, including their understanding of the term; as well, it provides ideas for informing the development of questionnaire items for the larger sample. The quantitative design allows us to examine to what extent it is appropriate to generalise our results to a wider population, and affords us the opportunity to test the probability of some events occurring by chance. Also, by careful attention to research design it allows us to demonstrate cause and effect relationships among variables. In essence, the two contrasting designs allow for both depth and breath of findings to be incorporated within a single study. What had started out as a qualitative research study has been complemented by use of a quantitative analysis. We have moved from an inductive perspective to a deductive one, from an idiographic paradigm to a nomothetic one. Recall, In Phase 1 most of the information was obtained through semi-structured interviews where respondents were allowed to say in their own terms what the important issues were for them; while it was possible to begin to make general statements about what might be important for the "average" nurse these have to remain speculative until we ascertain the views of more nurses. For instance, if

our hunches are correct we should expect to find that a larger sample of nurses would rate staff-on-staff conflict and aggression as more distressing for them than aggression from patients or others, that nurses are not any more aggressive compared to other groups of workers, that nurses subscribe to task/time imperatives, and so forth (Chapter 7 details the issues to be addressed in Phase 2). By using a survey method to collect data we can quantify nurses' views and advance notions of the commonality of aggression in nursing. Thus, we will have moved from the particular experience of the individual to the general experience of the many.

In conclusion, we have seen that there are methodological and theoretical uncertainties surrounding each research tradition. And philosophers of science are unlikely ever to agree on the best approach. Regardless of the research paradigm one subscribes to - the "hard" paradigm in which the person is object versus the "soft" paradigm which emphasises the subjective and person-centred approach - we would do well to heed Bertrand Russell's (1929) comments:

> We are.....led to a somewhat vague distinction between what we may call "hard" data and "soft" data. This distinction is a matter of degree, and must not be pressed; but if not taken too seriously it may help to make the situation clear. I mean by "hard" data those which resist the solvent influence of critical reflection, and by "soft" data those which, under operation of this process, become to our minds more or less doubtful (p. 75).

Finally, whether it is preferable to interview one person a 1000 times or to interview 1000 people once is something for each researcher to decide. Nurse researchers need to be selective in their choice of research method and sceptical of all knowledge claims. Getting the "best" answer is never simple. Different approaches can help advance our critique of what we think we know.

CHAPTER SEVEN

PHASE TWO: THE LARGER SAMPLE PERSPECTIVE

7.1 Introduction

Phase 1 provided information on what nurses define as aggression, including the meaning, extent and nature of aggression experienced at work. In this second phase we turn to a larger sample to see if a) respondents hold similar views to those obtained at Phase 1 regarding the nature and extent of aggression, and b) to determine causal structures via an experimental design and a path model. This chapter outlines the overall research design, the major areas for investigation during this phase, and the recruitment and the characteristics of respondents.

7.2 Overall research design

Phase 2 is based on a survey-embedded experimental design involving a sample of 270 nurses. Respondents watched a short video clip of an aggressive encounter between two nurses (Appendix 3) and completed a questionnaire (Appendix 4). It was not possible to obtain a random sample of nurses because of inability to secure a list of the names and addresses of all nurses in the population. Also, because of the rural nature of the state it would have been difficult to include nurses working in remote regions; time and travel costs would have been prohibitive. Still, it was possible to randomly assign participants to the different

versions of the video scenario in order to examine the effects of hierarchy on participants' judgements (see below and Chapter 8 where hierarchy as a determining factor in respondents' blame placement is considered).

This design was chosen for several reasons. Firstly, with a survey a wide array of data can be gathered relatively quickly. Schuman and Kalton (1985 cited in Singleton et al., 1988) suggest that the scope of information gathered in surveys can be classified into five dimensions namely: social background information (eg, how old are you?); reports of past behaviour (eg, what is the level of aggression that you currently experience?); attitudes, beliefs and values (eg, considering everything are you satisfied with your job at the present time?); behaviour intentions (eg, how will you vote in the next election?; and sensitive information (eg, what is the most distressing aspect of your work?). Answers to the questions can sometimes be obtained from records or observation, but often much of this information may not be directly known and it is only by asking individuals that we can obtain this information. And while the experimental design usually allows for testing of only one hypothesis, the survey can address many research questions (Singleton et al., 1988).

The main disadvantage with survey data is that cause and effect relationships are difficult to establish compared to experimental designs. In a survey, attempts to "control" for extraneous variables are made after the data have been collected via statistical control, thus cause and effect relationships are made with less confidence in surveys compared to experimental designs. To overcome some of these limitations an

experimental design was incorporated within the survey. Experiments can pre-determine the relationship between the independent (IV) and dependent variables (DV) so that the IV comes before the DV. In surveys, measurement normally occurs at one point in time so that the direction of causality is not so easily established. Also, because experiments randomly assign participants to control and experimental groups the problem of eliminating extraneous variables can be better resolved than in survey research.

Both survey and experimental design can be criticised for the possibility of producing respondent reactivity whereby respondents give socially desirable responses to sensitive questions. Also, both may be criticised when respondent behaviour is assumed to equate with respondents' responses to a questionnaire. Without the benefit of observation, it is debatable whether what respondents say they would do in a given circumstance translates into actual behaviour should such a circumstance actually arise. Of course, the results from qualitative research are open to doubt too. Respondents may, with the best will in the world, tell you what they think you want to hear and not what may be important to them. However, if the apparent candid responses provided by respondents in Phase 1 are anything to go by there is support for believing that the respondents in Phase 2 will not be any less honest in their responses, especially given the anonymity ensured by this research design.

7.3 The major areas for further investigation

1. Nurses' experience of aggression

The respondents in Phase 1 indicated that aggression is a major factor in their work and we should expect to see this view supported among a larger sample of nurses. However, the extent of staff-on-staff aggression needs to be examined in relation to the many other potential sources of aggression that nurses may experience. Nurses may be aggressed against from patients, doctors, patients' relatives, other disciplines and so on. To complete the picture the extent that nurses may be aggressive themselves towards others needs investigating too.

2. The nature of aggression experienced

Findings from Phase 1 suggest that most of the aggression that nurses receive relate to the verbal-active-direct (as in rudeness), verbal-active-indirect (as in gossip), verbal-passive-direct (as in others refusing to speak to you) and verbal-passive-indirect (as in others failing to speak up for you in your absence) domains. It is expected that there will be few reports of physical abuse.

3. Nurses' reaction to aggression

As discussed above, nurses' well-being can be seriously affected following patient assault, but what of other reactions? Recall, at

Phase 1 it was suggested that aggression may have positive effects as well as negative ones. For instance, people may develop insight into their own behaviour following an incident. Therefore, we need to explore possible positive reactions as well as negative ones to aggression in order to capture as wide a response range as possible.

4. Nurses' reaction to aggression

Knowing the actions that nurses take following incidents of aggression together with an estimate of their helpfulness would be important to have prior to the implementation of strategies to help reduce the impact of aggression on nurses. On the basis of respondents' comments at Phase 1 it might be expected that they would derive most benefit from talking with a colleague and least from a nurse manager.

5. Aggression at work compared to other work stressors

The views of respondents at Phase 1 indicate that aggression from nurse colleagues causes them most concern. In an investigation such as this there is the possibility of being accused of highlighting aggression at the expense of other more important stress-related work aspects. Therefore, to avoid this criticism respondents will be asked to rate how distressing aggression is for them compared to other possible work stressors. From the information obtained at Phase 1 it is anticipated that nurses will rate aggression from their

colleagues as of more concern to them than aggression from other sources. However, it is not clear if aggression will be nurses' main work concern. Studies that have sought to ascertain what nurses find stressful in a given work setting have produced varied results. In a review by Wilkinson (1994), on the stress associated with cancer nursing, a speciality that has been traditionally identified as a particularly stressful occupation (McElroy, 1982), stresses have included the long and unpleasant treatments patients receive, conflicts between nurses and doctors (Wilkinson, 1986), feelings of being inadequately prepared to meet patients' and their families' emotional needs (Gray-Toft and Anderson, 1981; Harris et al., 1990), caring for dying patients (Vachon, 1978; Gray-Toft and Anderson, 1981), work overload (Donovan, 1981) and difficult relations with administration (Barstow, 1980; Harris et al., 1990).

6. Task/time imperatives: are they a reality?

The notion that staff are constrained by task/time imperatives requires closer scrutiny in the context of understanding some of the possible circumstances surrounding workplace aggression. First, we can ask, do staff who break these imperatives suffer the same level of sanction as staff who commit "obvious" acts of aggression, eg, shouting at another? Second, to what extent are staff wedded to task/time imperatives?

The above areas for investigation in Phase 2 report mainly descriptive data (Chapters 8 and 9), the following sections deal with attempts to

determine cause and effect relationships among variables (Chapters 10 and 11).

7. Aggression and hierarchy

It was noted above under Phase 1 that participants saw aggression arising mainly between colleagues of similar status, although managers were implicated, it was often for their benign indifference to staff difficulties rather than their outward aggression towards staff that was complained about. The impression from respondents is that aggression occurred within and between all grades of staff. Is it simply a fact that aggression is given and received in an indiscriminative fashion? Is it true that, regardless of a nurse's status within the hierarchy, (s)he "gets it in the neck" just because (s)he "transgressed" or happened to be in the "right" spot at the "right" time for the other to unload her/his aggression? If the contentions, as suggested above by theorists, that aggression in nursing is both generational and hierarchical in nature then we might expect to see aggression "played out" in ways that relate to these considerations. We saw in Phase 1 above that respondents were sympathetic to patients being aggressive but the same consideration was not apparent when colleagues were aggressive. Lanza (1984b) noted that subjects' age, sex, and assault experience were predictive of their blame placement preferences when asked to assign blame after reading a vignette about an assault by a patient on a nurse. But what of the characteristics of the protagonists themselves? A ready

"marker" for nurses in practice is their grade or level within the hierarchical work structure. The work a nurse does is often dependent on her grade. Might there be "acceptable" aggressive behaviour for each of the different grades? It was alluded to in Phase 1 that novice nurses are very quickly socialised into the nursing culture. Given that an important aspect of this culture revolves around the notion of horizontal violence, it might be expected that the aggression meted out to junior staff will be seen in a different light to the aggression occurring between "seasoned" staff. Initiation to nurses' dominant culture orientation - one that stresses task/time imperatives - occurs early in a nurse's career and breaking of this cultural norm might be expected to incur a more sever rebuke when it occurs among junior staff than among more senior colleagues. The question is begged. Are nurses' perceptions of aggression swayed by protagonists' grades in determining blame placement? Answers to this question would go some way towards understanding nurses' anchor points when determining their conception of an aggressive act. It would also help determine the extent that aggression is a socially construed manifestation, in this context dependent for its interpretation on the ranks of those involved in the altercation. For instance, we can ask is the acceptability of an act of aggression mediated as a result of the job status of the protagonists?

8. Aggression: the vicious circle

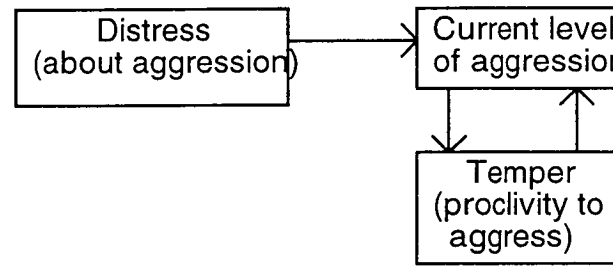
Given that we don't have objective measures of the current level of workplace aggression how then do we infer its existence? One obvious way is simply to ask workers, as was done in Phase 1. In other words, the level of workplace aggression is what workers say it is. Given that it exists because workers say it does, the next question is to ask why it persists. Two reasons are proffered here.

First, not all workers are concerned about aggression to the same extent. As we have previously discussed (Chapter 2), what some may call aggressive, others may more euphemistically refer to as boisterous behaviour. Presumably too, there will be some workers who are not too concerned about working alongside aggressive colleagues or for that matter aggressive clients. Therefore, a certain level of aggression may be tolerated by some workers. Further, it is conceivable that abrasive colleagues or clients and busy work environments may be welcomed by some staff as they like the challenge they engender. Parkes (1982) found that student nurses' morale increased when their job demands went up. These nurses indicated that they had a greater sense of being busy and useful when workload increased. However, on the basis of respondents' views at Phase 1 we might expect that most nurses would be concerned about staff-on-staff aggression. This brings us to the second reason why workplace aggression may persist. Once aggression occurs, for whatever

reason, it is likely to recur, particularly where aggression is allowed to go unchecked or where there are no sanctions in place to prevent its recurrence or when there are no respected role models available to present alternative non-aggressive responses to adversity and conflict. Some of the respondents at Phase 1 remarked how angry it made them when colleagues were abusive towards them or when they had seen others suffering abuse. Not only did they want to retaliate but the anger itself added to their distress about aggression in the workplace and increased their resentment towards the aggressor or the organisation that allowed it to happen. In a review by Wykes and Whittington (1994:111) empirical evidence suggests that anger and morbid hatred are common responses of health care staff following incidents of aggression. Angry individuals are likely to "attract' aggression or at least become embroiled in angry exchanges (Johnson, 1990) and so the circle of negative relations between others and colleagues persists - put simply, aggression breeds aggression. While each of us may have our own unique anger threshold (Johnson, 1990), if the views of respondents at Phase 1 are correct we should expect to see a rise in workers' temper levels as a result of staff-on-staff aggression at work.

Thus far, the above argument suggests that without objective measures of workplace aggression we have to rely on workers' opinions - the level of aggression at work is what workers say it is. An individual's concern or distress about workplace aggression will influence her/his perception of the amount of workplace

aggression, the higher the perception of workplace aggression the greater the worker's proclivity to aggress (temper) which, in turn, contributes to more aggression. Highly angry and stressed individuals are likely to engage in abrasive interactions with others and the cycle of aggression continues. The model below illustrates this line of argument.



The likely impact of three other variables on this model are discussed below. If respondents' views at Phase 1 are correct for a larger sample of nurses we should expect to see that high levels of job satisfaction correlate with low levels of distress/concern about workplace aggression. Some respondents intimated that low morale and job satisfaction were frequent among staff in areas where staff were worried about the extent of staff-on-staff aggression. But it is not clear if job satisfaction is a cause or a concomitant of one's concern about workplace aggression. Job dissatisfaction may arise as a result of a myriad of factors outside and/or inside the work setting. For instance, marriage disharmony or perceived inadequate pay may be responsible for affecting workers' job satisfaction levels. In a review by Holt (1983 cited in Neff, 1985: 255) on the effects of job stress on physical and

emotional health and on job satisfaction he found no clear relationship between job stressors and unfavourable outcomes. This might reflect the fact that job satisfaction is influenced as much by outside as well as inside factors. In light of this, job satisfaction is conceived as an exogenous variable in the model; in other words, when workers have negative feelings about their job these will increase their estimation of perceived level of aggression at work. Also, we would expect to see a negative relationship between level of distress regarding workplace aggression and job satisfaction.

Mental well-being is another possible influence on perceived level of workplace aggression. People bring with them a variable mental health profile to the work setting. It is generally believed that in an organisation there may be as many as 25-30 percent of workers suffering from an emotional upset (Jenkins, 1992: 11). Of course, this is not to deny the importance of environmental factors within the organisation as a determinant of mental ill health too. Similar to the discussion above surrounding job satisfaction, a worker's mental health status may be related to factors intrinsic to the job, as in work relations and/or to factors outside the workplace, for example, recent life events (Jenkins, 1992: 17). While it may be expected that most workers will be emotionally upset on account of staff-on-staff aggression compounding this upset will be the psychological baggage that each worker brings with her/him to the workplace. We know that some people will develop psychological ill health after little or no discernible stress,

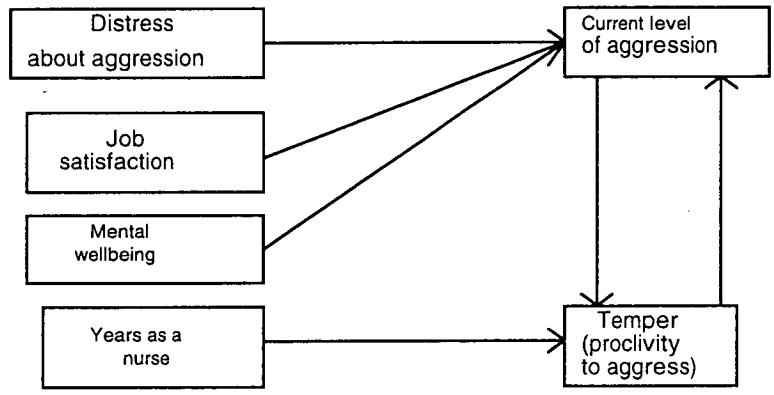
whereas others appear able to cope following major multiple traumas (Goldberg and Huxley, 1992: 82). Therefore, for present purposes, the effect of one's mental well-being is assessed for its impact on one's perception of workplace aggression. Because there is some evidence for suggesting that the happier people are with their jobs the healthier they are psychologically (Kornhauser, 1965 cited in Baron, 1986:162), we'd expect to find a positive relationship between these two variables in the model proposed.

The final variable for consideration relates to the number of years the person has been in nursing. Interestingly, some respondents at Phase 1 alluded to the fact that those who had been in the job for many years could be particularly aggressive. In nursing, it is possible to remain on the lowest grade for many years, or indeed until one retires. If respondents' views are correct at Phase 1 years in nursing will positively influence proclivity to aggress.

In light of the discussion thus far, the following model is suggested (Figure 7.3.1). Perceived current level of workplace aggression is modelled as a function of perceived workplace distress (on account of the individual's sensitivities to aggression), job satisfaction, mental well-being and temper. Temper (proclivity to aggress) , in turn, is modelled as a function of perceived current level of workplace aggression and number of years in nursing. Perceived current level of workplace aggression is dependent on temper and vice versa. The model is non-recursive, ie, the path can be traced between the latter two variables an infinite number

of times and never be forced to return to the remaining (exogenous) variables. Operationalization of these variables is discussed in Chapter 11.

Figure 7.3.1 **Aggression Breeds Aggression**



It is expected that the variables distress, job satisfaction and mental well-being will be correlated with one another, viz: high levels of distress will be associated with low mental well-being and low job satisfaction and low job satisfaction will be associated with lower mental well-being. The model also allows for a correlation between current level of aggression and temper.

7.4 Recruitment of participants

Participants were recruited from two main sources - at the University of Tasmania and at a large general hospital in Tasmania. At the School of Nursing, University of Tasmania, many hospital-trained nurses are upgrading their qualifications to a degree in nursing usually through part-

time study. Lecturers running classes for these courses were approached to see if they were willing to set aside class time for the researcher to explain the purpose of the study and to recruit participants. During this time the nature of the study was explained in terms of it being a follow-on study from the previous year and that the researcher wanted to see if a larger sample of nurses had similar views to those in Phase 1. Nurses were not told of the specific findings of Phase I. They were informed that the researcher wanted to hear their views about the nature and extent of aggression in their clinical settings and that such information was a necessary first step before any recommendations about training in aggression management could be made. The voluntary nature of the study was reinforced, ie, agreement or refusal to take part would not affect their assignment grades or their job in any way. Apart from the hope that the study itself would generate interest the only inducement offered to potential participants was the promise of light refreshments following participation. Nurses were reassured about the anonymity of their responses and the researcher promised to feedback results to those participating at a later date via an open forum at their hospital. Time was set aside for questions. Interestingly, and as for Phase 1, many nurses asked if I was interested in hearing about aggressive colleagues as well as aggressive patients. Once it was apparent that there was interest to take part in the project a mutually convenient time was set aside for nurses to participate in the study. This was usually the following week when they were back in class. The vast majority of nurses contacted in this way agreed to participate in the project. Immediately prior to participating in the study participants were given an "Agreement to Participate" form in order to help reinforce the

voluntary nature of the study (Appendix 5). This form was "posted" in a box which was kept by the researcher. During the completion of the questionnaire the researcher remained in the room and was available to answer any queries. All participants had virtually the same detailed introduction about completing the questionnaire and for watching the video. It was pointed out that it was important that nurses' individual views were obtained and that there were no right or wrong answers. It was emphasised that respondents should complete the questionnaire on their own. To increase the feeling of anonymity respondents were told to "post" their completed questionnaires in the box labelled "Completed Questionnaires".

In the hospital, negotiating access and meeting staff was much more problematic. First, the executive director of nursing for the hospital was approached in person and the study was introduced as per above. As well, a brief outline of the study was left for the director to pass on to the relevant programme directors of nursing at the hospital (Appendix 6). On the advice of the director of nursing, a letter was sent to the director of medical services at the hospital to enquire if the study needed ethics approval from the hospital research and ethics committee (Appendix 7). It was several weeks, and many phone calls later, before both parties agreed that the study could go ahead. Next, individual ward charge nurses/clinical nurse managers were approached in person to seek their assistance with the project. They were asked if the researcher could explain the project to the staff on the ward and if they could release those staff that were keen to take part. Ward staff were approached, usually at handover time, and their participation in the study was sought.

These staff were given similar information to that given to the nurses at the university. Again, as far as it could be ascertained, the vast majority of staff approached were keen to take part. Many indicated that they felt such a study was important. Often several visits were required to individual wards and departments before participants could be recruited for the study. Apart from the need to explain the study to potential respondents and seek a mutually convenient time to participate in the project there was also the unpredictability inherent in nurses' work, so that on some occasions meetings had to be cancelled because of increased work demands on staff or they were off duty or sick, etc.

Most of the charge nurses approached were helpful and assisted with setting times for the researcher to speak with staff and in releasing them to participate in the project. To overcome the fact that the researcher was unknown to hospital staff and to help introduce the project - that in this context ward managers might be expected to shy away from - a research assistant who was well known to hospital personnel was recruited. The research assistant proved a major asset in that he had high credibility in and knowledge of the local scene. He was also invaluable in that, because of a lack of an appropriate room with television and video facilities on some wards and units, he was available to direct staff to the appropriate "study" rooms. These rooms were sometimes some distance from participants' wards. To avoid possible concerns by respondents about anonymity because the research assistant was well known to many of them, they were informed that he was not involved in any way with the collection of completed questionnaires or with their analysis, that he was there to assist with the

practicalities of the research and to help network with staff on behalf of the researcher.

An intensive period of data collection was carried out over a six-week period both at the hospital and the university. Wards were visited at handover times in the afternoons, evenings, week ends and at night. It was not possible to say how many of those approached refused to take part in the study. Those who did participate appear to be representative of Tasmanian nurses on many variables thought relevant for this study (see below).

7.5 Sample characteristics

A total of 270 practising nurses were recruited for this phase. This represents 5% of nurses currently holding a practising certificate in this state. As can be seen in Table 7.5.1 below there were many more females in the sample than males. This is to be expected where, on average, male nurses represent about 10% of the nursing workforce. Most respondents were at level one staff nurse grade. While few had postgraduate qualification, such as, diplomas in advanced nursing, many had obtained their Bachelor of Nursing (BN) since qualifying as hospital trained nurses.

Table 7.5.1 **Characteristics of the Sample (n=270) Compared to the Tasmanian Nursing Workforce (N=5340)**

	Sample data	Tasmanian data**	I_d#
Mean age:	36 sd 9*	42 sd 13	3
Sex: Females:	85%	92	
Males:	15	8	7
Mean number of years as a nurse:	15 sd 8	19 sd 15	2
Prof. qualifications:			
Registered Nurse (RN):	79%	81%	
Enrolled nurse:	21%	19%	2
Grade of nurse:			
Level-1:	60%	48%	
Level -2:	19	22	
Level-3:	6	8	
Level-4:	.5	1	
Enrolled Nurse:	15	17	
Other	----	4	3.9

Further comparisons between the sample data and the Tasmanian nursing workforce data was not possible due to different collection procedures or because the data were not available.

	Sample data
Postgraduate qualifications:	
Yes (when BN counted as a postgraduate qualification):	28%
Whether working in public or private setting:	
Public:	78%
Private:	20
Both Public & Private:	2
Work area:	
Medical ward:	14%
Surgical ward:	20
Pool/on call:	8.9
Psychiatric ward	6.7

The remainder worked in a variety of settings.

On contract:	
Yes:	31
No:	79
Shift work:	
Night shift	10
Day shift:	85
Both day and night work:	5

Full/part-time work:

Full time:	56%
Part time:	34
Casual/on call:	10

Marital status:

1. Single:	20%
2. Defacto relationship:	11
3. Married for first time:	53
4. Remarried:	5
5. Separated:	4
6. Divorced:	6.5
7. Widowed:	.5

KEY: * Rounded to nearest whole number.
** These data were obtained from the 1995 Tasmanian Workforce Data (TWD) survey.
There were no further data available from the TWD survey to make comparisons with the remaining
sample characteristics.
Refers to index of dissimilarity (see below).
Note: due to missing data figures for some variables do not add to 270.

To see to how the "sample" compared to the population of Tasmanian nurses indices of dissimilarity were calculated for those characteristics for which data were available for comparisons to be made. The computation for each index of dissimilarity was calculated as follows:

$$I_d = {}^1/_2 \quad [\, dist_1 - dist_2 \,].$$

For each variable, its sample and population distribution were subtracted from each other and this difference (if any) was divided by two. Note, plus and minus signs are ignored in calculations. The age of respondents in the sample were on average six years younger than the average Tasmanian nurse. The index of dissimilarity for age is therefore 3, ie, 3% would have to be shifted from one distribution to the other in order to have identical distributions on this variable. Other low indices of dissimilarity were seen for the variables: "Number of years as a nurse" (2%); "Professional qualifications" (2%); and "Grade of nurse" (3.9%). The largest dissimilarity index was seen for the variable "Sex" (7%). In the "sample" there were seven percent more males than in the Tasmanian population of nurses. Also note that the sample had 12 percent more Level-1 nurses compared to the Tasmanian nursing workforce. This may reflect the fact that there are more Level-1 nurses working in hospitals, where the data collection was mainly undertaken, compared to community and other settings. Community nurses are generally at Level-2 or higher. Therefore, any generalisations to a larger population outside the hospital setting should be treated with caution.

The following chapter examines to what extent the concerns raised during Phase 1 surrounding the nature and extent of aggression in clinical settings are relevant for a larger sample of nurses.

CHAPTER EIGHT

THE NATURE AND EXTENT OF AGGRESSION IN NURSES' CLINICAL SETTINGS

8.1 Introduction

Following Phase 1 there was the concern about the applicability of the findings for a larger sample of nurses. In this chapter an estimate is given about the extent of nurses' concern among a sample of 270 clinical nursing staff. In light of the theoretical insights outlined at the end of Chapter 5 we should expect to see respondents in Phase 2 endorsing the following propositions:

1. At work nurses are more concerned about aggression from nurse colleagues than aggression from patients or others;
2. Staff-on-staff aggression is common in many different clinical settings;
3. Aggression from colleagues is a major work distress factor for nurses;
4. Both females and males report broadly similar views; and
5. The major forms of aggression among staff are: verbal-active-direct (as in rudeness), verbal-active-indirect (as in gossip), verbal-passive-direct (as in others refusing to speak to you) and verbal-passive-indirect (as in others failing to speak up for you in your absence). There will be few reports of physical abuse.

Additionally, this chapter provides information on nurses' reactions to aggression, the actions they take following incidents of aggression and the helpfulness derived from these actions. It might be expected

in light of respondents' comments at Phase 1 that few respondents will see their nurse managers as being helpful. Aggression at work is compared to other work stressors and men's and women's responses are compared where appropriate.

8.2 Development of questionnaire items

The following eight questions are part of a larger questionnaire as per Appendix 4).

(a) Nurses' experience of aggression

Question 6 asked respondents for their views concerning the extent of aggression that they had either witnessed or been personally involved in. Respondents were asked to rate the frequency of the aggression on a six-point scale where one indicated that aggression was extremely unlikely and six indicated that aggression was extremely likely. This question attempted to cover most of those thought likely as being either the instigators or receivers of aggression within a nursing context, for example, nurse to nurse, patient to nurse, relative to relative and so on. This list was constructed following discussion with academic nurse colleagues and on reflection on the conversations held with respondents during Phase 1. Recall, in Phase 1 respondents were asked to rate the extent of aggression occurring between: patients to staff; patients to patients; staff to patients; and staff to staff. Question 6 elaborates on these four "types" of aggression in an attempt to offer more specific indicators as to who is seen as being aggressive to whom.

(b) The most distressing "type" of aggression to deal with

Question 7 attempted to ascertain from whom or between whom nurses see aggression as being the most distressing to deal with. Respondents were asked to circle the "type" of aggression that for them is the most distressing to deal with. While nurses may, eg. cite a high level of staff-to-staff aggression it does not necessarily follow that such aggression bothers them most. Although from respondents' comments in Phase 1 above one might expect to see staff-to-staff aggression as being the most difficult "type" of aggression to deal with.

(c) Nurses' current experience of aggression

Question 8 asked respondents to rate their current level of aggression experience on a six-point scale where "1" indicated no aggression experienced and "6" indicating aggression on a daily basis. Whereas questions 6 and 7 attempted to ascertain a global estimation of aggression question 8 and the remaining questions attempted to anchor nurses' experiences in the here-and-now. It was felt important that nurses' views of their current experience of aggression be obtained, otherwise it would be difficult to discuss present practice and to make recommendations for the future.

(d) The nature of aggression experienced

Question 9 looked at the nature of nurses' aggression experience. Respondents were asked to check as many items as applicable from a predetermined list of 22 items. A six-point scale was used to

ascertain the frequency with which each item was experienced, where "1" indicated infrequent experience and "6" indicated frequent experience. Ideas regarding item inclusion were gathered from the information supplied in Phase 1 (see Buss's typology of aggression - physical-verbal, active-passive, and direct-indirect, Chapter 3, p. 82), from recent literature on this subject (Turnbull, 1995; Adams, 1992; Bassman, 1992; Ryan and Oestreich, 1991; Lanza, 1983) and following discussion with colleagues and respondents in Phase 1. To avoid the possibility of omitting important items the final item "Other" offered respondents the opportunity to add individual comments. In pilot-testing this aspect of the questionnaire among student nurses (n=15) none checked the "Other" category. It is recognised that such a list could be much longer and a decision had to be made over which items to include and which ones to leave out. For instance, Lanza (1983) included 108 categories to choose from in an attempt to identify nurses' reactions following assault from patients. For present purposes the final choice of items was felt to be reasonably comprehensive to gauge the nature of nurses' aggression experience. Response categories are expressed in broad terms, the details of particular aspects of aggression, say "Rudeness" or "Humiliation in front of others" are not asked for as it was felt that such detail would add an undue amount of time for completion of the questionnaire and much of this detailed information is already available in Phase 1.

(e) Those typically responsible for nurses' aggression

Question 10 asked respondents to say who they feel is typically responsible for the aggression they experience at work. Respondents were asked to circle as many "players" as appropriate from a pre-

determined list and there was space provided for respondents to include "players" omitted from this list. From an awareness of the sentiments expressed in Phase 1 it is expected that nurse colleagues will be implicated more so than other individuals.

(f) Nurses' reaction to aggression

Question 11 sought information on the reaction of respondents to aggression. A range of possible reactions were presented for respondents to check (Loss of confidence, Anxiety, Depression, Sleep problems etc.). As with question 9 above ideas for item inclusion arose from the literature and from discussion with participants during Phase 1. Although much of the literature on workers' reactions following aggressive incidents has emphasised negative responses (eg, Adams, 1994; Whittington and Wykes, 1992; Flannery et al., 1991; Rowett, 1986; Lanza, 1983) there is the possibility that aggression may result in positive outcomes too, for instance the person may reflect on the part they played in the encounter and feel that the incident was a good learning experience. Therefore, one item asked about a positive reaction (eg, Helped me gain insight into my own behaviour). A six-point scale was used to gauge the level of respondents' reactions for each of the items, where a score of "1' indicated no reaction and "6" indicated a strong reaction.

(g) The action taken following incidents of aggression and the helpfulness derived from these actions

Question 12 sought respondents' views about the action they took following incidents, eg, talked about situation with person concerned,

talked about situation with manager, and so on. Items for inclusion were derived from consultation with colleagues and on a review of the literature. In answer to this question respondents were asked to check the item(s) that applied. To ensure as wide a response as possible space was provided for respondents to document actions other than those supplied.

It is expected that respondents will be in need of both practical and emotional support following incidents of aggression, therefore question 13 asked if the actions taken were helpful.

(h) Aggression at work compared to other work stressors

Question 14 attempted to estimate the distress caused by aggression compared to other stress-related work activities. In order to avoid cuing individuals regarding what might be distressing for them it was left up to respondents to nominate a particular stressor or not as the case may be. Many of the studies on stressors and their effects on nurses used pre-selected items and were not based on stressors which were generated by respondents (Lee, 1987), therefore it is difficult to know how relevant these stressors were for respondents in these studies.

For those respondents who nominated something other than aggression as their major source of workplace distress a supplementary question was included which asked them to compare aggression to their most distressing concern. For this they were asked to rate aggression on a scale of one to nine, where "1' indicated that aggression was hardly a concern and "9" indicated that

aggression was almost as bad as their most distressing concern. It is assumed that a one-off estimation such as this can be a good indicator of the relative importance of aggression for respondents. In relation to job satisfaction, it has been found that a single item asking about one's level of job satisfaction can provide a good overall indicator of employees' feelings (Bruce and Blackburn, 1992: 32).

The above two questions had two main aims. First, to avoid accusations of highlighting aggression at the expense of other distress factors at work and second, to offer an estimate of the relative importance of aggression compared to other distress factors.

Most of the above questions ask respondents to give an overall estimation of the problem and not arrive at a specific number of incidents of aggression. For this, semantic differential rating scales were constructed which attempted to gain a subjective assessment of the problem (Oppenheim, 1966). In this way, problems of recall of the number of specific incidents was avoided. Hodgkinson and Edelstein (1972) in Treece and Treece (1982) urge caution about respondents' ability to record even factual information in questionnaires. Moreover. estimation of the precise number of incidents can be seen as redundant in the sense that even minor assaults can have profound consequences for those involved (Whittington and Wykes, 1989; Lanza, 1983). People act not just on the "facts" but on what they perceive the situation to be. What was aimed for in these questions was an estimation of the relative level or frequency of occurrence of aggression for each of the different items.

Note, in the present study, results for only some questionnaire items are presented here and in the following chapter as the author is conducting a larger study than is reported in this thesis.

Finally, as discussed in Chapter 7 where it was suggested that in light of the controversy surrounding differences between women and men regarding aggression it would be relevant to compare the sexes on certain variables. For instance, Bruce and Blackburn (1992) contend that most women use a framework of "caring" and relationship maintenance during decision making whereas men are motivated to use a framework of "justice", being realistic and enforcement of rules as their main criterion of decision making. If this is so, one might expect conflict between male nurses and their female managers. Specific differences between the sexes are described and discussed below under the relevant sections where comparisons were made.

8.3 Data analysis and results

For purposes of quantification, questionnaire item scales were considered at the interval level of measurement. Strictly speaking, the data are at the ordinal (or equal-interval-appearing) level of measurement, however it is not intended that scores are to be seen as a definite measure, rather the intention is that they provide an approximation of the differences between and within respondents' perceptions. For ease of readability, where statistical tests are used these are discussed at the relevant sections below. Because we are dealing with a non-random sample it was felt inappropriate to include statistical probability estimates for these tests.

8.3.1 Stability of nurses' responses

To help establish the reliability of some of the above questions ten nurse colleagues were asked to answer Question 6 (which contained 19 separate items) and Question 8 (which contained one item) on two separate occasions five days apart. Respondents' second questionnaire results were compared with their first using Pearson product-moment correlations. A coefficient was calculated for each respondent (Table 8.3.1.1).

Table 8.3.1.1 Correlation between Respondents' First and Second Questionnaire Responses

	CORRELATIONS	VARIANCE ACCOUNTED FOR
	.71	50%
	.80	64
	.91	83
	.78	61
Question 6	.62	38
	.66	44
	.76	58
	.73	53
	.87	76
	.77	59
Question 8	.90	81

From the above table it can be seen that there was a reasonable degree of consistency among many of the respondents in their responses for each of the two question items.

8.3.2 Nurses' experience of aggression

Question 6 sought nurses' experience of aggression. Table 8.3.2.1 provides a preliminary breakdown of both the direction and level of

aggression experienced between nurses, doctors, patients, and patients' relatives.

Figure 8.3.2.1 The Level and Direction of Aggression Between Nurses, Doctors, Patients and Patients' Relatives

		Instigator			
		Nurse	Patient	Relative	Doctor
Recipient	Nurse	3.51*	3.74	3.96	3.97
	Patient	2.56	2.58		
	Relative	2.24		3.36	
	Doctor	3.17			

KEY: * Mean score, where 1 = Aggression extremely unlikely & 6 = Aggression extremely likely.

The above table indicates that doctors, patients' relatives, patients, nurse colleagues in that order are perceived as being most aggressive towards nurses. Nurses perceive themselves as the most likely recipients of aggression too. Note also that aggression between the relatives of patients is perceived as being of a similar level to the aggression between nurse colleagues. A more detailed breakdown of who is seen as being aggressive to whom is provided in Table 8.3.3.1 below.

8.3.3 The most distressing "type" of aggression to deal with

By summing the number of times a particular "type" of aggression was checked by respondents staff-to-staff aggression accounted for 25%

of the total checks for all items (Table 8.3.3.1). Aggression from patients' relatives to nurses accounted for nearly 16 % of responses; doctor-to-nurse aggression accounts for over 10 % of responses; patient-to-nurse aggression accounted for 10 % of responses; aggression from nurse managers to nurses junior to them is next in importance; and so on.

(a) Female and male views

When responses for women and men are analysed separately for the above two questions we find that women's views mirror that for the total sample. This is not surprising, perhaps, given that 85 percent of respondents were female. Therefore, caution is required in drawing any conclusions about difference between male and female nurses in this study. Male nurses saw things a little differently than their female counterparts. For instance, nurse-to-nurse aggression was thought by men to be the seventh most likely "type" to occur (Table 8.3.3.2).

The sexes also differed with respect to the "types" of aggression thought most difficult to deal with (Table 8.3.3.2). Examination for the five most distressing "types" of aggression to deal with we find that women were most distressed by aggression from nurse colleagues, patients' relatives, doctors, patients and clinical nurse managers, in that order; men also rated aggression from nurse colleagues as being most distressing for them, but their second most distressing "type" of aggression is aggression from their nurse managers (Level-4 and above), followed by patient aggression, then aggression from patients' relatives, and finally aggression from doctors.

Table 8.3.3.1 Nurses' Views Regarding the Likelihood of the Different"Types" of Aggression Occurring and their Perceived Distress (n = 270)

Aggression "type"	Likelihood of aggression Mean*	S.D.	Most Distressing No. of checks	% of total checks+
1. From doctors to nurses	3.97	1.37	35	10.83(3)**
2. Patients' relatives to nurses	3.96	1.28	50	15.47(2)
3. Patients or their relatives to nurses over the telephone	3.77	1.41	17	5.26 (7)
4. Patient to nurse	3.74	1.41	32	9.90 (4)
5. Nurse to nurse (all grades)	3.51	1.37	80	24.76 (1)
6. Between the relatives of a pt.	3.36	1.41	4	1.23 (13)
7. Nurse managers (Level-4& above) to nurses junior to them	3.32	1.46	26	8.04 (5)
8. Clinical n/manager to nurses junior to them (Levels-1&2)	3.31	1.45	24	7.43 (6)
9. From nurses to doctors	3.17	1.32	6	1.85 (12)
10. From other disciplines to nurses	2.97	1.36	2	0.61 (14)
11. Levels-1&2 to clinical nurse managers	2.90	1.43	4	1.23 (13)
12. Levels-1-3 to nurse managers (Level-4 and above)	2.76	1.40	8	2.47 (10)
13. Non-nurse managers to nurses	2.76	1.40	4	1.23 (13)
14. Nurses to non-nurse managers	2.67	1.33	1	.30 (15)
15. Nurses to other disciplines	2.65	1.25	--	--- (16)
16. Patient to patient	2.58	1.32	2	0.61 (14)
17. Nurse to patient	2.56	1.27	9	2.78 (9)
18. Nurses to patients' relatives	2.24	1.03	13	4.02 (8)
19. Nurses to patients or their relatives over the telephone	2.14	1.06	6	1.85 (11)
Mean of means =	3.08	No. of checks = 323		100%

KEY:

* Where 1 = Aggression extremely unlikely & 6 = Aggression extremely likely.

\+ The no. of checks for each item was calculated as a % of the sum of checks for all items.

** Indicates which "type" of aggression was most distressing to deal with, with 1 indicating the most distress, 2 indicating the next most distressing item and so on.

Table 8.3.3.2 Women's and Men's Views Regarding the Likelihood of the Different "Types" of Aggression Occurring and their Perceived Distress

Aggression "type"	Likelihood of aggression Mean score*		Most Distressing % of checks+	
	Women	Men	Women	Men
1. From doctors to nurses	3.98	3.92	11.67 (3)	**6.12 (5)
2. Patients' relatives to nurses	3.98	3.87	16.78 (2)	8.16 (4)
3. Patients or their relatives to nurses over the telephone	3.74	3.92	5.83	2.04 (7)
4. Patient to nurse	3.71	3.92	9.54 (4)	12.24 (3)
5. Nurse to nurse (all grades)	3.53	3.46	23.72 (1)	30.61 (1)
6. Between the relatives of a pt.	3.39	3.16	1.09 (13)	2.04 (7)
7. Nurse managers (Level-4& above) to nurses jnr. to them	3.29	3.50	6.56 (6)	16.32 (2)
8. Clinical n/manager to nurses junior to them (Levels-1&2)	3.26	3.66	7.66 (5)	6.12 (5)
9. From nurses to doctors	3.16	3.23	1.82 (12)	2.04 (7)
10. From other disciplines to nurses	2.94	3.11	0.72 (15)	----- (8)
11. Levels-1&2 to clinical nurse managers	2.90	2.94	1.09 (13)	2.04 (7)
12. Non-nurse managers to nurses	2.79	2.68	0.72 (15)	4.08 (6)
13. Levels-1-3 to nurse managers (Level-4 and above)	2.77	2.58	2.55 (10)	2.04 (7)
14. Nurses to non-nurse managers	2.64	2.82	0.36 (16)	----- (8)
15. Nurses to other disciplines	2.58	3.03	----- (17)	----- (8)
16. Patient to patient	2.55	2.73	.73 (14)	----- (8)
17. Nurse to patient	2.52	2.82	2.94 (9)	2.04 (7)
18. Nurses to patients' relatives	2.22	2.39	4.04 (8)	4.08 (6)
19. Nurses to patients or their relatives over the telephone	2.07	2.57	2.20 (11)	----- (8)
			100%	100%
		Number of checks:	274	49

KEY: * Where 1 = Aggression extremely unlikely & 6 = Aggression extremely likely.
+ The number of checks for each item was calculated as a percentage of the sum of the number of checks for all items, this was done separately for women and men.
** Indicates which "type" of agg'n was most distressing to deal with, with 1 indicating the most distress, 2 indicating the next most distressing item and so on.

8.3.4 Nurses' current experience of aggression

The mean score obtained for nurses' current experience of aggression was 3.01, SD: 1.42 (n=266). Where "1" = no aggression experienced and "6" = aggression experienced daily. This is similar to the score of 3.08 we get when the mean scores for each of the 19 "types" of aggression nurses experience are averaged (Table 7.3.4.1). When frequencies are calculated for responses on this variable (Question 8, Appendix 4) we find that about half of the respondents are reporting relatively little experience of aggression in their current work while nearly 30 % are reporting that they experience aggression on a daily or near daily basis, ie, having a score between four and six (Table 8.3.4.1.). Female and male respondents reported similar experiences.

Table 8.3.4.1 **Responses to Question 8 - Current Level of Aggression: Calculated in Percentages**

	Value	N	Percent
None at all:	1.	20	7
	2.	120	44
	3.	51	19
	4.	35	13
	5.	18	7
Daily:	6.	26	10
	Total	270	100%

(a) Comparison between work settings

When work settings were compared, staff working in accident and emergency settings and in acute care mental health units report the highest level of aggression (Table 8.3.4.2.).

Table 8.3.4.2 **Current Experience of Aggression by Setting Using Kruskal-Wallis 1-Way ANOVA StatisticalTest**

MEAN RANK	CASES	SETTING
123.58	12	Accident & Emergency
91.37	75	Intensive care/Surgical ward
84.69	39	Medical ward
122.53	18	Psychiatric ward
83.48	24	Pool/on call
66.59	11	Rehabilitation-general

Chi-Square: 17.6560

In light of the large number of different work settings respondents worked in, it was decided to include for comparison only areas that had 10 or more respondents working in them. Seven settings met this criterion. Inspection of boxplots indicated that respondents from intensive care units and surgical wards had a similar profile in terms of aggression experience, and as these two areas are broadly similar in terms of the care they provide for patients these two sets of data were combined. Apart from these two settings boxplots indicated that the other settings were not comparable in their distributions on this variable suggesting that the level of aggression experienced by staff is not the same for all six settings.

8.3.5 The nature of aggression experienced

Respondents indicated that they most frequently experienced rudeness followed by abusive language, humiliation (examples of verbal-active-direct aggression), and so on at work (Table 8.3.5.1).

Table 8.3.5.1 Nature of Aggression

Label	Mean	SD	N
Rudeness	3.16	1.53	214
Abusive language	2.62	1.53	203
Humiliation in front of others	2.49	1.42	207
Others failing to speak up for you in your defence	2.25	1.43	190
Denied access to opportunities	2.09	1.50	188
Others stealing credit for your work	2.08	.00	195
Being refused help to enable you to perform necessary tasks	2.06	1.26	194
Excessive scrutiny of your work	1.92	1.34	186
Others spreading malicious rumours about you	1.86	1.35	189
Unjustified criticism	1.81	1.34	176
Others refusing to speak to you	1.80	1.30	192
Unjustified criticism	1.72	1.26	184
Threats of physical assault	1.64	1.20	182
Other	1.63	1.41	56
Physical assault	1.59	1.19	180
Set up to fail	1.57	1.17	184
Others refusing to move out of your way	1.51	1.05	184
Threats of disciplinary action	1.38	1.03	180
Others telling lies about you	1.37	. 88	183
Threats of job loss	1.25	.86	181
Damage to your property	1.12	.55	177
Threats to your family	1.10	.52	178

Note: For each item a score of "1" indicates an "infrequent" occurrence whereas a score of "6" indicates a "frequent" occurrence.

8.3.6 Those typically responsible for nurses' aggression

Nurse colleagues, patients, patients' relatives, doctors, nurse managers, in that order are particularly likely to be perceived as being

typically responsible for the aggression respondents currently experience (Table 8.3.6.1). The extent of nurse-to-nurse aggression stands out when aggression from nurse colleagues and nurse managers is combined. This is similar to the picture given above for Question 6 (Table 8.3.3.1), indicating that those who are seen as causing most distress to respondents are also those who are seen as the "givers" of the aggression.

Table 8.3.6.1 **Those Seen as Being Typically Responsible for the Aggression Nurses Currently Experience**

	Frequency of the number of times each "type" of aggression was checked	
Aggression from nurse colleagues:	126	21.77%
Aggression from patients:	120	20.90
Aggression from pts' relatives:	110	19.16
Aggression from doctors:	106	19.16
Aggression from nurse managers:	78	13.41
Aggression from non-nurse managers:	16	2.78
Aggression from others:	16	2.78
TOTAL:	572	100%

Aggression from nurse colleagues, nurse managers, and non-nurse managers accounts for 38 percent of the aggression received. To see to what extent each of the work settings, as discussed above, reported similar levels of aggression from colleagues, doctors, patients and so on the following tables are presented.

Table 8.3.6.2 (a) Comparison Between Work Settings for Those Thought to be Typically Responsible for the Aggression Nurses Experience

	THOSE TYPICALLY RESPONSIBLE FOR THE AGGRESSION						
SETTING	1	2	3	4	5	6	7
Accident & Emergency	50*	-	-	83	92	50	17
Intensive care/Surgical ward	44	29	-	44	49	43	4
Medical ward	51	31	8	38	59	44	5
Psychiatric ward	17	28	11	94	22	44	17
Pool/on call	58	25	4	46	54	42	4
Rehabilitation-general27	27	9	55	36	55		

KEY: * refers to the percentage of times the item was checked within each setting
1 = nurse colleagues
2 = nurse managers
3 = non-nurse managers
4 = patients
5 = patients' relatives
6 = doctors
7 = others

In all of the above work settings non-nurse managers and "others" were cited as being the least responsible for the aggression that respondents experienced. Apart for the psychiatric setting and to a lesser extent the rehabilitation setting, aggression from nurse colleagues was a frequent occurrence in the other four work places. Aggression from patients was particularly high in accident and emergency and psychiatric settings. However, aggression from patients' relatives was considerably lower in the psychiatric setting compared to the accident and emergency setting. Approximately 50 percent of respondents from each of the six settings indicated that doctors were responsible for the aggression they encountered.

Note, the above table hides the fact that when the aggression from nurse colleagues, nurse managers and non-nurse managers is combined into one category of aggressor, nurses are thought to be typically responsible for aggression in four out of six settings .

Table 8.3.6.2 (b) **Comparison Between Work Settings for Those Thought to be Typically Responsible for the Aggression Nurses Experience**

	THOSE TYPICALLY RESPONSIBLE FOR THE AGGRESSION				
SETTING	1	4	5	6	7
Accident & Emergency	50*	83	92	50	17
Intensive care/Surgical ward	73	44	49	43	4
Medical ward	90	38	59	44	5
Psychiatric ward	56	94	22	44	17
Pool/on call	87	46	54	42	4
Rehabilitation-general	63	55	36	55	-

KEY: * refers to the percentage of times the item was checked within each setting
1 = nurse colleagues; nurse managers; non-nurse managers
4 = patients
5 = patients' relatives
6 = doctors
7 = others

8.3.7 Nurses' reaction to aggression

Table 8.3.7.1 below indicates nurses' reactions to aggression.

Table 8.3.7.1 Nurses' Reactions to Aggression

Reaction	Mean	SD	No of times item checked
Anxiety	4.03	1.55	223
Anger	3.83	1.57	211
Helped me gain insight into my own behaviour	3.66	1.71	187
Loss of confidence	3.52	1.74	209
Tried to forget about incident	3.51	1.76	188
Other reactions, eg, cry, burnout, ask why?	3.46	2.28	24
Irritability	2.93	1.61	193
Self blame	2.85	1.66	191
Sleep problems	2.84	1.79	191
Fear	2.82	1.78	180
Headaches	2.75	1.75	190
Depression	2.74	1.72	185
Considered leaving nursing	2.63	1.93	188
Wanted to get even	2.33	1.74	182
Poor work performance	2.29	1.49	181
No real effect	2.24	1.59	165
Change in eating/ drinking habits	2.17	1.66	179

Note: For each item a score of "6" indicates a "very much" response whereas a score of "1" indicates a "not at all "response. Most respondents checked more than one item.

Anxiety and anger were the two most frequently checked reactions, and these were also the two most severe reactions to aggression.

Interestingly, many respondents indicated that aggression from others helped them gain insight into their own behaviour.

(a) Analysis of interdependence of nurses' reactions to aggression checklist

To see to what extent the above reactions can be grouped or reduced to fewer variables so that the reactions of respondents are easier to understand an *analysis of interdependence* was performed (Chatfield and Collins, 1980: 8). There are many different types of *analysis of interdependence*, including principal component analysis (PCA) and factor analysis (FA). FA contains a number of different types of analyses. However, they all have in common the attempt to reduce a large number of interrelated variables to a relatively small number of constructs or components which can be uncorrelated. A good solution is one that is both parsimonious, ie, the observed correlations are represented using as few components as possible, and interpretable, ie, new insights and a deeper understanding of the data are realised (Norusis, 1985). Choosing between the two main techniques is problematic and few statisticians are neutral about them (Norman and Streiner, 1986). Both FA and PCA are primarily concerned with accounting for variation or variance (*common variance or shared variance*) which is shared by the scores of people on three or more variables. Total variation also includes two other kinds of variance: s*pecific variance* and *error variance*. *Specific variance* is accounted for by the variation which is specific or unique to a variable and which is independent of other variables; *error variance*, on the other hand, occurs as a result of measurement error, this may be due to poor technique or unreliable instrumentation. *Unique variance*

refers to the combination of *specific* and *error variance* (Bryman and Cramer, 1994: 259). An essential difference between FA and PCA relates to how they handle *variance*. In PCA , all the variance of a score or variable is analysed, no distinction is made between its *unique* and *common/shared variance*, ie, it assumes that the test used to assess the variables is perfectly reliable and without error. Thus, PC is accounting for all the variance in the observed variables by as many components as there are variables. FA requires fewer factors because it analyses only common/*shared variance*, ie, FA attempts to exclude *unique variance* from analysis. In FA an estimate of the *common variance* is put in the principal diagonal of the correlation matrix, usually Rsquare, whereas in PCA the main diagonal is made up of unity (1.00). Another difference between these two approaches is that FA relies on a proper statistical model, in PCA there is no underlying statistical model (Chatfield and Collins, 1980). However, FA relies on a large number of assumptions, which according to Chatfield and Collins (1980: 88) are not always realistic in practice. Also, different FA methods may produce different results for the same set of data. Further, it is not always easy to select the "correct" number of factors. Even though a test is available for this, it too depends on the model assumptions. The situation can arise in FA where the form of the factors (as determined by which factor loadings are "large") change completely when the number of factors change. In contrast, the components derived in a PCA are unique. They remain unchanged as one varies the number of components which are thought to be worth including (Chatfield and Collins, 1980: 88-89). In the clinical context, Both FA and PCA can be criticised to the extent that their results depend entirely upon the set of correlation coefficients, uncorrelated findings are neglected, which may pose

problems when comparing differences between groups (Chassan, 1979: 316). In most practical situations, Chatfield and Collins (1980: 89) suggest, PCA will be of more value than FA, simply because it makes fewer assumptions about the data; although where a researcher assumes that a number of observable indicators (variables) can be explained by a latent construct (a factor) then it may be more appropriate to compute a FA in preference to a PCA. And if one is concerned about how each method handles error, as discussed above, then FA, is at least, intuitively, more appealing. At any rate, whether PCA or FA is chosen, both analysis should be treated with caution as they are both, at best, an approximation of reality and it can be dangerous to read too much meaning into components or factors without corroborating evidence.

In the present context, PCA was chosen for two main reasons. First, the items for nurses' responses to aggression were not chosen a priori to reflect different reaction clusters (latent constructs). Given the paucity of previous research on the issue it would have been inappropriate to suggest which items would "go together". Second, in a review by Goldberg and Williams (1988), PCA has been used extensively in studies on the General Health Questionnaire (GHQ). The GHQ asks subjects to rate their responses to a series of questions about their physical and emotional health and in the present context, where respondents were asked to rate their reactions following aggression, it was felt appropriate to also use PCA to explore for possible dimensions (Table 8.3.7.2).

Table 8.3.7.2 Varimax Rotated PCA for Nurses' Reactions to Aggression (Pairwise Deletion of Cases)

Item no.		Principal components loadings 1	2	3	Communality
3	Depression	.84	.26	.04	.76
1	Loss of confidence	.74	.10	.22	.60
6	Self blame	.70	.10	.12	.52
4	Sleep problems	.69	.34	-.16	.62
5	Poor work performance	.68	.15	-.15	.51
2	Anxiety	.68	.28	.04	.55
7	Fear	.66	.23	.06	.50
8	Change in eating/drinking habits	.63	.38	-.15	.57
13	Considered leaving nursing	.60	.20	-.00	.41
12	Wanted to get even	.15	.77	.18	.65
11	Anger	.33	.74	.01	.66
9	Headaches	.49	.58	-.19	.62
10	Irritability	.53	.56	-.02	.60
14	Tried to forget about incident	.05	.34	.68	.58
16	Helped me gain insight into my own behaviour	.41	-.25	.62	.62
15	No real effect	-.15	-.02	.58	.36
	Eigenvalues	6.50	1.41	1.21	9.12
	% Total variance	40.6	8.8	7.5	57.00

Note: item 17 "other" was removed from analysis as only a few respondents checked this item and for those respondents who wrote down their specific reactions in the questionnaire a variety of responses were given.

The first principal component (PC) accounted for almost 41 % of the total variance and all three PCs accounted for 57 % of the variance. Nine items loaded highly (.6 and above) on PC one. These were: Depression; Loss of confidence, Self blame, Sleep problems, Anxiety, Fear, Change in eating/drinking habits, and Considered leaving nursing. These items can be seen as negative reactions to aggression and include mainly psychological responses, in essence a "stress" response/construct. The following four items had the highest loadings on PC two: Wanted to get even, Anger, Headaches, and Irritability. The latter two items also had moderate loadings on PC one. PC one accounted for nearly as much as the variances in these two factors as did PC two. PC two can be seen to represent an "angry" response to aggression, and it might be expected that headaches and irritability would also be seen in the "stress" response. PC three points to a "reflective" response as the items loading high on this PC were, Tried to forget about the incident, Helped me gain insight into my own behaviour, and No real effect.

(b) Internal consistency of nurses' reaction to aggression checklist

Cronbach's alpha was calculated for each of the above three constructs in order to assess their internal consistency Table 8.3.7.3 presents corrected item-total correlations and standardised alpha values for the items associated with each response "type"/dimension - stress; angry; and reflective. Nunnally (1978) suggests that alpha values of .6 and above are acceptable. On the basis of this criterion, two out of three of the alpha values obtained were satisfactory. For the responses stress and angry the alpha values were .89 and .79 respectively. The third dimension ("reflective" response) had an

unacceptably low alpha of .31. Perhaps, the small number of items contributed to this dimension's low alpha value.

Table 8.3.7.3 Reactions to Aggression Checklist: Corrected Item-Total Correlations and Standardised Alpha Values

Construct/ dimension	Item	Corrected item-total correlations	Alpha
STRESS	3	.81	
	1	.63	
	6	.57	
	4	.68	
	5	.60	
	2	.65	
	7	.63	
	8	.63	
	13	.54	.89
ANGRY	12	.52	
	11	.65	
	9	.59	
	10	.65	.79
REFLECTIVE	14	.21	
	16	.22	
	15	.10	.31

(b) Construct validity of the reactions to aggression checklist.

Bearing in mind the above views regarding the utility of PCA (and FA) and in light of Chassan's (1979: 319) comment that when these methods are applied to heterogeneous groups of subjects without regard to differences in characteristics between subjects that may

influence the size and sign of correlation coefficients, the approach on its own must be regarded as a rather crude tool for the statistical description of clinical observation, it was felt important to determine to what extent these factors were salient dimensions rather than artificial statistical outcomes. Because of the nature of the variables loading high on the second PC it might be expected that these individuals would also be quick tempered. Therefore, it was hypothesised that there would be a positive correlation between respondents who were quick to temper and PC two scores only, ie, those respondents who responded angrily to encounters would also have high scores on a temper test. Pearson product-moment correlations were computed between individuals' scores for each of the three PCs and respondents' responses to an existing inventory that measures temper/proclivity to aggress (see Chapter 11). The correlation between the PC two scores and temper test scores was $r = .40$ The correlations for PC one and PC three and respondents' temper test scores were each at $r = .12$. This indicates that PC two is a better predictor of respondents' temper test scores than either of the two PCs and lends tentative support for the notion that respondents behave in characteristic ways following aggressive incidents.

8.3.8 The actions taken following incidents of aggression and the helpfulness derived from them

Table 8.3.8.1 provides information on respondents' actions, including their perceived helpfulness, following an aggressive incident.

Table 8.3.8.1 **The Actions Taken and their Perceived Helpfulness Following Incidents of Aggression**

Action	Percentage of respondents reporting		No of times action was helpful
Talked with colleagues	72% (195)*	22%**	132 (68%)+
Talked with friend	58 (157)	18	85 (54%)
Talked with family member	52 (140)	16	78 (56%)
Talked with person concerned	51 (139)	16	77 (55%)
Talked with manager	49 (133)	15	68 (51%)
Kept it to myself	17 (45)	5	11 (24%)
Talked with union/prof org'n	12 (33)	4	18 (55%)
Sought professional help	7 (19)	2	12 (64%)
Talked with human resource personnel	6 (16)	2	9 (56%)
Other	3 (9)	1	6 (67%)

Key: * refers to number of respondents checking each item.
** refers to the percentage of total responses
+ refers to the number of times that respondents found each action helpful expressed as a percentage, eg, 132/195 * 100 = 68% (approx).

From the above table it can be seen that the most popular course of action - Talking with colleagues - was also the most helpful. Of the other most popular courses of action, talking about the incident with a manager was thought to be least helpful. Few respondents thought the action - Kept it to myself - as helpful. Involving professional help or other "outside" agencies, although helpful, were not options for most respondents.

8.3.9 Aggression at work compared to other work stressors

Under half of the respondents (45%) indicated that "aggression" caused them most distress, with aggression from colleagues being

most frequently cited for this group of respondents. Just over 54% of respondents cited "something" else (Table 8.3.9.1).

Table 8.3.9.1 The Most Distressing Aspect of Nurses' Work

	Frequency of the number of times a response was mentioned (n = 254)	
Aggression from colleagues:	67	26.58 %
Aggression from patients:	33	13.09
Aggression from doctors	5	1.98
Aggression from colleagues and doctors:	5	1.98
Aggression from colleagues and pts/relatives:	4	1.58
Aggression from colleagues and patients:	1	0.39
Something other than aggression:	137	54.36
No work distress:	2	0.79
TOTAL:	254	100%

In an attempt to group these comments the work of Gray-Toft and Anderson (1981) was drawn upon. These authors found it possible to conceptualise nurses' distress under seven headings namely: death and dying; conflict with doctors; inadequate preparation; lack of support; conflict with nurses; work load; and uncertainty concerning treatment. In the present study, four nurses and the researcher independently categorised each of the response items according to the above seven headings. Following the first round of categorisation the researcher determined which categories met the criteria for inclusion under one of the above seven headings. An item was said to meet inclusion under a category providing that there was 80% of

agreement among the raters, ie, there was agreement among at least four of the five raters. Following the first round there was 80% or above agreement for 89 of the 137 responses. To decide on the remaining responses another round of categorisation was begun where consensus was sought about the remaining responses and their appropriate categorisation. Following this meeting only 14 responses remained without a category. To accommodate six of these remaining responses a new category was agreed upon, namely: Coming up to own expectations/feeling inadequate. This left a total of eight items grouped as "miscellaneous" as they contained a variety of items that proved impossible to categorise under another name (Table 8.3.9.2).

Those respondents who indicated that their distress at work was related to something other than aggression were asked to rate the distress caused by aggression on a zero-to-nine-point scale, where a score of five was taken to indicate that aggression was half as distressing as the respondent's most troublesome concern and a score of nine indicating that aggression was almost as distressing as the respondent's most troublesome concern. The mean for this question was 5.02, SD: 2.47, which indicates that aggression is half as distressing compared to the distress caused by respondents' most troublesome concerns. Examination of frequencies for this question indicate that 20 % of respondents see aggression on a par with their most troublesome concerns. Respondents who cite lack of support as their most troublesome concern have the highest average scores for aggression as a distress factor (Table 8.3.9.2).

Table 8.3.9.2 **The Most Distressing Aspect of Nurses' Work Other Than Aggression**

	Frequency of the number of times a response was mentioned (n =137)	Mean aggression score
a) Workload (eg, not enough time to complete work, support patient)	40	4.51
b) Death and dying (eg, the death of a patient):	30	5.00
c) Conflict with other nurses (eg, difficulty in working with a particular nurse):	16	5.54
d) Inadequate preparation (eg, feeling inadequate to meet patient needs):	15	5.23
e) Lack of staff support (eg, lack of opportunity to share feeling with staff):	10	6.00
f) Conflict with physicians (eg, disagreement concerning a patient's treatment):	8	5.43
g) Coming up to own expectations (eg, fear of failure):*	7	5.67
h) Uncertainty concerning treatment (eg, not knowing what to tell a patient):	3	4.00
i) Miscellaneous responses:	8	4.57
TOTAL:	137 MEAN:	5.02

KEY: * Not included among Gray-Toft and Anderson's (1980) seven distress factors.

Items c, e, and f can be seen as representing aggression too in light of the discussion with respondents during Phase 1. However, these respondents elected to answer the supplementary question, thus indicating that they did not regard their comments to be taken as "aggression". It may be that they may have misinterpreted the requirement for this part of the question. Overall, the questionnaire appears to be both reliable and valid as per the discussion below.

8.4 Reliability and validity of the questionnaire

The similarity of students' second responses to their first for questions six and seven suggests that these parts of the questionnaire are reliable estimates of nurses' concerns. That responses to the questionnaire were in line with expectation, ie, they provide evidence which supports the views of the respondents in Phase 1, suggests that the questions are a valid indicator of nurses' perceptions. Recall, in Phase I clinically-based staff thought that aggression from patients was more likely to occur than staff-to-staff aggression and this is confirmed here. However, respondents from both the university and clinical settings voiced most concern about the level of colleague conflict over and above that of aggression from others and there is evidence that this is the case here too. Validity is further supported when one considers that some of the results are generally consistent with previous findings on what nurses see as their most distressing work-place concerns. Aspects of the questionnaire were also found to correlate with other measurement tools in use. Nurses' characteristic reactions to aggression, ie, "anxious", "angry" and "reflective" were shown to correlate as predicted with their scores on an aspect of a tempter test used in studies by London and Spielberger in the USA. The variable response rate to questions lends support for the view that respondents were expressing individual views and concerns and were not cued to respond because of social bias. Spontaneous feedback from many respondents following completion of the questionnaire, indicated that they thought it was both comprehensive and relevant.

8.5 Discussion

The major focus of this part of Phase 2 was to ascertain the nature and extent of aggression in nurses' clinical settings. The extent of nurse-on-nurse aggression was compared to other sources of aggression in nurses clinical settings. Women's views were compared to men's and the extent of aggression in different work settings was compared. Also, nurses' reactions to aggression were examined and aggression at work was compared to other work stressors.

8.5.1 Nurses' experience of aggression.

When respondents were asked which "type" of aggression they had been personally involved in or witnessed at work doctor-to-nurse aggression headed the list, followed by aggression from patients' relatives to nurses; patients or their relatives to nurses over the telephone; patients to nurses; finally nurse-to-nurse aggression and so on in that order. However, it is nurse-to-nurse aggression that respondents cited as the most distressing to deal with, followed by aggression from patients' relatives, then doctors, patients, nurse managers (Level-4 and above) and so on.

8.5.2 Comparisons between women and men

Recall, the opportunity was taken to compare women's and men's responses as there is uncertainty in the literature about sex differences in relation to aggression. Both women and men rate nurse-to-nurse aggression as the most distressing to deal with. Men,

although they report only slightly more aggression from their nurse managers than do women, they rank aggression from their managers as their second most distressing aggression "type" to deal with. For women this source of aggression does not feature among their "top" five concerns. Women are more concerned than men with aggression from patients' relatives and doctors.

Men's concerns about their nurse managers' aggression towards them occurred regardless of where they worked. To account for men's distress caused by their nurse managers many possible explanations can be proffered. Baron (1977) indicates that men may have a lower "boiling point" than women and in Frodi's (1977) study, men were more ready than women to respond to direct verbal insult particularly when weak provocations were used. In the present study it may be that men found it more difficult to deal with authority figures who are aggressive towards them on account of the fact that they were female (in the present context most of the nurse-managers are female). Confrontation by a female boss may result in more loss of face and self-esteem for men than women and men may feel inhibited to retaliate to their female manager. Men's greater concern may also indicate their greater sense of insecurity about job loss, particularly if they are or see themselves as the main bread earners in the family. Differing management styles between men and women may be another factor.

In the nursing context, it is men who are in the minority and at ward level it is often women who are in charge. It may be that this concern of men reflects their expectations regarding female management styles. Although the research is patchy on female and male

managers' work styles, Bruce and Blackburn (1992) suggest that women and men managers do differ. In their study, these authors asked female and male manager how they would respond after reading a vignette detailing an employee's deteriorating work performance. Women managers were more concerned about not severing relationships and about helping, men were concerned about role-related obligations and organisational rules. If this is so, one might expect conflict between male nurses and their female managers. Male employees may be more resentful of female managers who they see as not "sticking by the rules".

Also, differences between the sexes may be accounted for in relation to men's sex role stereotyping of their female managers. Bruce and Blackburn (1992), suggest that while men and women may approach problem solving differently, successful managers tend to arrive at the same resolution, nevertheless, when employees (at all levels of organisations) talk about their female managers, they focus on personality, rather than on objective performance measures. They contend that people expect women to sacrifice performance for niceness, and that productive women are viewed as unfeminine. Thus, when employees hold different sets of expectations about how female and male bosses should behave conflict is likely to ensue. In the present context, one possible explanation for male respondents' perception of their female bosses' aggressive behaviour towards them may have arisen as a result of how they think female nurse managers ought to behave. Of course, these speculations have to remain tentative due to the small numbers of male respondents and the lack of corroborating evidence. On a more general level, sex role stereotyping is a powerful influencer on perceptions. "In our culture

we have been carefully taught that a woman's place is in the home. Despite mounting evidence to the contrary, cultural messages die hard" (Bruce and Blackburn, 1992: 60). It is difficult for women to transgress sex role stereotyping to become career people (Smith, 1985).

Women, after colleague aggression, rate aggression from patients' relatives their second most difficult "type" of aggression to deal with yet both men and women report similar levels of aggression from the relatives of patients. Relatives sometimes vent their frustration and feelings of guilt and inadequacy in the form of criticism of nurses' care of their relatives and it may be that such attacks on nurses' care affect women more than men. In one study, it was found that female nurses in a general hospital had higher expectations of patient care compared to mental health-psychiatric nurses. In the psychiatric sample 30 percent were male nurses (Farrell, 1991). Also, there is evidence to suggest that women approach decision making in a framework of "caring" and relationship maintenance, whilst men are inclined to use "justice" as the main criterion of decision making (Bruce and Blackburn, 1992: 62). If this is so, women nurses may be expected to become more upset than men when patients' relatives complain about poor care.

8.5.3 Nurses' current experience of aggression

The above indicated a global estimation of aggression at work. When respondents were asked to focus on the level of aggression they currently experience at work nearly 30 percent indicated that they are subjected to aggression on a daily or near daily basis. Nurse

colleagues, patients, patients' relatives, doctors, nurse managers, non-nurse managers, and others, in that order, are thought of as being typically responsible for this aggression. Respondents were concerned in the main about verbal-active-direct aggression (see Buss's typology of aggression, Chapter 3) as seen in rudeness, abusive language, humiliation in front of others and verbal-passive-indirect forms of aggression, eg, others failing to speak up for them in their defence, being denied access to opportunities, and so on, meted out to them by colleagues and others.

These findings bear out much of the views of Phase 1 respondents who emphasised the importance of staff-to-staff aggression. The findings lend support for Cox's view that verbal abuse in nursing is so common it is surprising that nurses stay in the profession (Cox, 1987). In her survey of nurses in Texas, Cox found that nurses reported that doctors followed by patients' relatives were nurses' most frequent verbal abusers. A similar result is reported here when respondents were asked in general terms about the overall level of aggression encountered at work, however, it is nurse colleague aggression that respondents found most distressing to deal with. Cox also found that nurses' turnover rates were not affected by either doctors or patients' relatives' aggression towards them but it was directly related to perceived verbal abuse from nurse supervisors. Immediate supervisors ranked fourth on the list of staff nurses' source of verbal abuse. Cox's results might be seen to indicate, in a roundabout way, that nurses find abuse from nurse supervisors more upsetting than any other source. In a recent reader survey by McMillan (1995) many of the nurses who wrote or telephoned said they had endured many months or even years of bullying at the hands of their line managers

or colleagues. Respondents to this survey indicated that they were subjected to: unjustified criticism of their work; humiliation in front of others; being denied access to opportunities; excessive scrutiny of their work; being set up to fail; threats of disciplinary action; others stealing credit for work; others telling lies about work; abusive language; and physical abuse, in that order. The survey indicated that nurses are vulnerable in all specialities, in both the state and private sector settings. While line managers were implicated for most of the bullying, colleagues of similar rank were also identified as bullies, "confirming the view that anyone who is in a position of financial, organisational, or emotional dependence could be taken advantage of" (p. 41).

Why are nurses so concerned about their colleagues' aggression towards them? It is not the most common "type" of aggression experienced. In Phase 1 it was suggested that nurses could "accept" patient aggression - rationalising it in terms of the circumstances surrounding the patient's illness, perhaps, a similar notion of "acceptance" is entertained by respondents for doctors and to a lesser extent, especially for females - see discussion below on comparisons between women and men - for patients' relatives too. Certainly, it is not uncommon to hear nurses excusing a doctor's abuse because of stress due to long work hours and job hassles. It might be that patients' relatives are being excused because of the strain associated with having a sick family member. It may also be that aggression from colleagues, including immediate supervisors and managers has more "punch" simply because nurses are not always in a position to withdraw from interactions with "nasty" colleagues. With patients and doctors nurses can sometimes exercise a measure of

choice regarding the extent of their contact with them. During Phase 1 there were many examples of colleague behaviour which were not only intimidating but also frustrating to the individual to the extent that some nurses left the particular agency. Also, as alluded to above at Phase 1, the threat as well as the carrying out of sanctions may be more serious when a supervisor or manager is the aggressor, thus increasing the stress on the individual.

8.5.4 Comparison between different work settings

In four out of six of the work settings studied, as a group nurses, nurse managers and non-nurse managers were found to be particularly aggressive towards respondents.

When different work settings were compared staff reported aggression overall to be highest in accident and emergency departments and psychiatric wards, followed by intensive care and surgical wards, medical wards, pool/on call and finally general rehabilitation (ie, non-psychiatric), in that order. Because of the small numbers of respondents in some of these settings caution is required in accepting these results, although they are in keeping with expectations. Results from a large UK study indicated that staff working in psychiatric and accident and emergency departments were the most likely to be recipients of aggression (Health Services Advisory Commission, 1987).

However, the above is a global estimation of aggression for each of these settings. When respondents from these settings were asked to indicate who was aggressive towards them the accident and

emergency department stood out from the rest. Accident and emergency staff reported high levels of aggression from patients and from patients' relatives. Also, approximately 50 percent of these staff reported aggression from colleagues and doctors. To work effectively in such an environment the nurse would need skills in managing angry patients and their relatives, staff, and doctors. Interestingly, none of the accident and emergency staff indicated that their manager was aggressive towards them.

Workers in the psychiatric setting and to a lesser extent staff in rehabilitation indicated that aggression from colleagues was not as frequent as in other settings. In all settings there was consistent perception of doctors being aggressive. Approximately 45 percent of respondents in each setting perceived doctors as aggressive towards them.

These results indicate the importance of disentangling the sources of staff aggression as each area has a different profile of aggressors. To effect change it is vital that the source of the problem is firstly, correctly identified and secondly, appropriate actions are taken to effect change. It is likely that the skills and strategies needed to cause long-term change among nurses will be different to those required to calm patients' relatives. And to sharpen our focus further, information is also needed from staff about which aggressor is most upsetting. As has been shown above, the most frequent perpetrators of aggression are not necessarily the most distressing for staff. With this added information resources can be tailored to meet staff's most pressing needs in each particular work setting.

8.5.5 Nurses' emotional and physical reactions to aggression

Respondents reported three characteristic responses to aggression. There was an "anxiety", an "angry" and a "reflective" reaction. The "anxiety" response included mainly psychological responses, such as, depression, fear, sleep problems and so on. The "angry" response consisted of, irritability, headaches, anger, and wanting to get even. Those adopting a "reflective" response said they tried to forget about the incident, that aggression had no real effect, or that it helped them gain insight into their own behaviour. Support for the existence of these three response types was evidenced by the fact that the "angry" response, compared to the other two response types, showed a higher positive correlation with an existing inventory designed to measure respondents' temper levels. The current findings are consistent with those of Spielberger (1988 cited in Johnson, 1990). This author suggests that people express their anger in three distinct ways: they are those who suppress it (Anger-In), those who express it (Anger-Out) and those who are more reflective and controlled (Anger-Control/Reflection). In studying these three coping styles people are usually asked to respond in broad terms to hypothetical situations. For instance, Johnson (1990) provides the following response categories: I would get angry or mad and show it; I would get angry or mad, but keep it in; I would try to stay calm and solve the problem with a discussion at a later time; I would get annoyed but would keep it in; I would get annoyed and show it to the hypothetical question, Imagine that your spouse (partner) criticized you, got angry and blew up at you in front of your relatives. What would you do? The findings of the present study indicate the sorts of emotional and behavioural responses people may experience within

each of the coping styles. They also indicate the variable response rate to provoking situations. Presumably, cognitive factors, including how we appraise events; past experience; personal coping strategies; and situational determinants impinge on how we respond in a given situation. As Johnson (1990: 10) notes, "anger is by no means a reflexive automatic response to provoking events".

8.5.6 Nurses' action following aggression

The most popular courses of action taken by respondents to attempt to resolve the aggression they experienced was to talk with colleagues, a friend, the person concerned, a family member or their manager, in that order. Few "kept it to themselves" or sought help from their union, human resource department or from other professionals. In a recent reader survey by McMillan (1995) in the U.K., the most frequent course of action taken by nurses following an incident was to talk with a friend, spouse or colleague. Talking with managers or union/professional organisations were the next most frequent options. Unfortunately, the U.K. survey did not ask if respondents spoke to the person concerned, so it is not possible to compare responses on this variable. The main difference between these two survey results lies in the greater willingness of the UK nurses to speak with their union/professional organisation following incidents of aggression. The UK nurses were more concerned about abuse from their managers than the nurses in the present study and this may be the reason for them seeking redress from their union/professional organisation. It is perhaps more likely one will try and resolve an incident on a face-to-face basis with a fellow colleague of equal or similar grade than with one's immediate manager, also the

taboo about "dobbing in" on work colleagues may be stronger in Australia. The preamble to the U.K. survey emphasised abuse from managers more so than abuse from colleagues. Abuse being defined as the improper and frequent use of power to affect someone's life adversely (Patchett, 1992). It may be that this emphasis cued respondents to give greater consideration to this aspect of aggression than that which occurs between nurses at all grades.

Turning now to the helpfulness of these actions, the most popular course of action - talked with colleagues - was endorsed as being the most helpful. Of the other most popular courses of action, ie, talking with friends, with the person concerned, with a family member, or with a manager were given similar levels of endorsement. A few respondents sought professional help, of which a majority thought was helpful. By far the least helpful course of action for respondents was to keep the aggression to themselves. In the McMillan survey unions or professional organisations and friends or spouses offered most support and, similarly to the present study, the option "kept it to myself" was the least useful course of action. However, talking with managers was not thought helpful in dealing with situations such as bullying, whereas in the present study talking with a manager was rated almost as highly as talking with a friend. This contrast may reflect a difference in staff and line manager relationships in each of the two countries. In the present study only 12 percent of respondents sought help from their union or professional organisation, this compares with 40 percent seeking help from these organisations in the UK sample, although in both cases the unions or professional organisations were thought to be equally helpful.

8.5.7 Aggression at work compared to other work stressors

Results indicate that aggression as a distress factor is high on respondents' concerns when compared with their most troublesome workplace concern. Almost half of the respondents indicated that aggression was the most distressing aspect of their work, with colleague aggression being most often cited. Over half of the respondents indicated something other than aggression as their most distressing work aspect. Although, when these respondents rated the distress caused by aggression they indicated that aggression is an important distress factor for them too. In light of the findings regarding who is seen as being typically responsible for the aggression that they experience, we can infer that these respondents are also alluding to colleague-inflicted aggression. Both groups of respondents are indicating that aggression is a major distress factor at work of which colleague initiated aggression is most prevalent. These findings are somewhat at odds with Gray-Toft and Anderson's (1981) findings. These researchers found that nurses reported experiencing most stress at work from the same three sources: work load, feeling inadequately prepared to meet the emotional demands of patients and their families, and death and dying. In a review by Lee (1987: 202), studies that report on nurses' stress at work indicate that there is a common core of stressors which include the death of patients, uncertainty about patient treatment, inability to meet patient needs and expectations, looking after dying babies, facing the shortage of skilled labour, communication and interpersonal problems with medical staff and supervisors, having family and life crises, poor self-esteem and insecurity about one's knowledge and competence and fear of failure. Nevertheless, support for the validity of the present

results is warranted. Recall, a fellow PhD student, conducting research on the effects of aggression on nurses on mainland Australia, was not surprised when Phase 1 results were related to him. In the USA Smythe (1984) commented on the extent with which nurses told her of colleague abuse during workshops she ran on stress management. Because respondents were focussed early on in the study to consider aggression and in light of the fact that they were not asked to choose from a predetermined list of potential stressors, as was the case in many of the previous studies on workplace stress in nursing, perhaps a more considered appraisal of the role of aggression was given in this study. Present results may also reflect nurses' greater willingness now to openly express their concerns. In industry, as in nursing, the veil shrouding abuse in the workplace is only now being lifted. In Australia, horizontal violence has recently been aired in the feminist literature on nursing (Street, 1992; Walker, 1994, Duffy, 1995). And in the popular nursing press in the U.K., the issue of abuse at work has recently been discussed in one of the U.K.'s most popular weekly nursing journals (McMillan, 1995; Turnbull, 1995).

8.6 Conclusion

This chapter has provided quantitative descriptive evidence that lends support for accepting many of the contentions proffered at the end of Phase 1 about the nature and extent of aggression in nurses' clinical settings.

In a review by Turnbull (1995), the conclusion is drawn that bullying at work is a significant problem for many organisations. The present

results indicate that nursing is no exception to what is rapidly being recognised as a major problem at work. In nursing and elsewhere employees place great store on having good colleague relations (Everly and Falcione, 1976; Argyle and Henderson, 1985: 241; Decker, 1985; Stamps and Piedmonte, 1986: 16; Blegen et al., 1992; Gilloran et al., 1994; and Carr and Kazanowski, 1995). Thus, in the present context, one might speculate that these results are in keeping with the notion that when there is an absence of goodwill among work colleagues the inherent stresses and strains associated with any job are thus more difficult to cope with.

CHAPTER NINE

TASK/TIME IMPERATIVES

9.1 Introduction

During Phase 1 it was mooted that an understanding of staff-on-staff aggression necessitated an awareness of nursing work culture. According to oppression theory, novice nurses are quickly "made into" "good" nurses. Such "complicity to oppression", Walker (1993: 160) contends, rapidly coerces nurses into docility (after Foucault, 1977:149. An essential element of this "making" and "shaping" can be seen in novice nurses' conformity to the dominant nursing social culture, one that stresses hierarchical power relations and obedience and adherence to strict task/time grids. Adherence to a task/time imperative can be seen as the backdrop in which staff conflict arises. It may not be the cause of aggression but it is likely to blind staff including nurse managers to experimenting with alternative and ultimately more productive work relations whenever conflict arises - as it inevitably will in most work settings. To be able to demonstrate such an adherence among a larger sample of nurses would lend further support to respondents comments at Phase I and to theorists' views.

9.2 Research question

To what extent are nurses wedded to "task/time" imperatives?

9.3 Operationalization of the variable "task/time" imperative

The variable "task/time" imperative can be seen as a latent construct. Unlike, say the variable "weight", there are no objective measures for its measurement. There are potentially many behaviours and attitudes that could go to make up this variable. In an effort to determine the degree to which nurses subscribe to "task/time" imperatives respondents were asked to complete a six-item inventory along the lines discussed by Oppenheim (1966: 97). Inventory items were selected upon reflection following the qualitative study reported above and after several discussions with a number of nurse colleagues who were not included in the study. Question items were pretested on a small sample of student nurses to check on their ease of administration and to ascertain the extent that each item could generate a wide response range. The following six items were retained for the final questionnaire: How bad is it if you/How good is it if you:

a) Occasionally arrive late for work;
b) Sometimes stay on duty after your shift has finished without overtime payment;
c) Take special pride in completing tasks by set times;
d) Forget to give a patient his medication on time;
e) Let some patients remain untidy; and
f) Find that you have to leave some tasks for the on-coming shift to complete?

This number of items was chosen partly due to consideration of the overall questionnaire length and on the advice of panel members who

felt that these six items captured the salient aspects of a "task/time" orientation. Items were scored as follows. Respondents were asked to check one of seven boxes labelled: Very bad; Fairly bad; Slightly bad; Slightly good; Fairly good; Very good; and It would depend in answer to each question. The lower the score the more respondents thought that subscription to an item was "bad". To attempt to limit the extent that respondents might be swayed to check items because of a social desirability bias item wording was carefully considered and the inventory was presented in a "permissive" fashion, eg, respondents were offered the option of checking the "It would depend" category for all of the items. (Appendix 4, Question 18).

9.4 Data analysis and results

As can be seen from Table 9.4.1 below respondents believe it is "bad" (response range from "Very bad" to "Slightly bad") to: "Occasionally arrive late for work" (item a), "Forget to give a patient his medication on time" (item d), "Let some patients remain untidy" (item e), and "Find that sometimes you have to leave tasks for the oncoming shift to complete" (item f), whereas it is thought "Very good" to "Take special pride in completing tasks by set times" (item c) and "Slightly good" (just) to "Sometimes stay on duty past one's shift without payment" (item b). Contrary, perhaps, to what might have been expected a majority of respondents did not choose the "It would depend" category for any of the items, thus indicating that they held definite ideas regarding their choices for the other response categories.

Table 9.4.1 **Average Scores for the "Task/Time" Inventory**

How bad is it if you How good is it if you	Mean* score	SD*	It would depend
a) Occasionally arrive late for work	2.76	1.69	15%
b) Sometimes stay on duty after your shift has finished without overtime payment	3.70	1.78	17
c) Take special pride in completing tasks by set times	5.38	0.91	4
d) Forget to give a patient his medication on time	2.10	1.78	12
e) Let some patients remain untidy	2.33	1.98	18
f) Find that sometimes you have to leave some tasks for the on-coming shift to complete.	2.71	2.09	26

Key: * The above statistics were calculated when the responses to "It would depend" were removed.

Note: Scores, one to three indicate an unfavourable response to the construct, whereas scores greater than 3.5 indicate a favourable response.

It was decided to remove the item "It would depend" from further statistical analysis as it was difficult to argue convincingly where it should be placed with respect to the other ordinal response scale items. On

reflection, an "It would depend" response can be taken to mean a "Don't know" response, ie, someone who has no opinion on the matter or be taken to mean the mid-point of the ordinal scale, ie, an attempt by the respondent to answer the question sincerely. Conceivably too, it may signal a "I don't care response - I can't be bothered to think the issue through". Grichting (1994) notes that "Don't know" in opinion surveys may be best considered as expressions of ignorance rather than indifference when there is no corroborating evidence to suggest otherwise.

9.4.1 Latent constructs

On first glance, Table 9.4.1. above may be seen to support the notion that respondents are supportive of a "task/time" orientation, nevertheless, we should proceed with caution with this interpretation. Although all items chosen for the inventory were designed to assess a "task/time" orientation it may be that the inventory is measuring more than one orientation. Inspection of a correlation matrix for these variables indicates that variables a, d, e, and f, are modestly correlated with one another whereas variables b and c are correlated, leading one to suspect that the above table may be better conceived as representing two constructs/dimensions. In an effort to see to what extent the above inventory might be represented by one or more latent variables/dimensions a factor analysis (FA) is reported. FA was chosen in preference to a principal components analysis in this instance because, unlike the situation in Chapter 8, all the items in this inventory were chosen a priori to reflect a "task/time" imperative. It was felt

appropriate to use this analysis, even though the data are at the ordinal level of measurement, because we are simply seeing if a more powerful statistical test yields a more interpretable solution. As previously discussed in Chapter 8, FA allows the researcher to see if a given number of variables can be transformed into new, uncorrelated variables and thus simplify the description of a set of interrelated variables.

The FA analysis yielded a two-factor solution. Four variables had moderate to high factor loadings on factor one. Of the two remaining variables, one (item c) had a moderate loading on factor two, variable b a small loading on factor two and a negligible loading on factor one (Table 9.4.1.1).

Table 9.4.1.1 **Varimax Rotated Principal Axis Factor Analysis for the "Task/Time "Inventory (Pairwise Deletion of Cases)**

Item	Factors 1	2	Communality
d Forget to give a patient his medication on time.	.74	.05	.56
e Let some patients remain untidy.	.69	-.23	.53
f Find that sometimes you have to leave some tasks for the on-coming shift to complete.	.55	-.17	.33
a Occasionally arrive late for work.	.43	-.00	.19

b Sometimes stay on duty after your work shift has finished without payment.	.00	.15	.02
c Take special pride in completing tasks by set times.	-.17	.66	.47
Eigenvalues	1.66	0.44	2.10
% shared variation	27.7	7.4	35.1

The first factor accounted for almost 28 percent of the shared variance and both factors accounted for just over 35 percent of the variance. In light of the variables loading high on FA 1 this was described as the "routine" dimension, ie, respondents were unwilling to deviate from that expected, eg, patients should be kept tidy and medication given on time. Factor two may be said to represent a "pride in work" dimension. However, using the criterion of including only those factors with an eigenvalue greater than "1", it is probably more appropriate to talk about a one-factor solution. Further support for accepting a one-factor solution is contained in the analysis below on internal consistency of items.

(a) Internal consistency of the task/time inventory

Table 9.4.1.2 presents the corrected item-total correlations and standardised alpha values for the items associated with each factor. The alpha values associated with the first factor (routine) was .68, which is within the acceptable range (Nunnally, 1978). The alpha value for the

variables associated with the second factor (pride in work) was low (.30) and well outside the acceptable range.

Table 9.4.1.2 Task/Time Imperative Checklist: Corrected Item-Total Correlations and Standardised Alpha Values

Component	Item	Corrected item-total correlations	Alpha
DUTY TO CARE	e) Let some patients remain untidy	.57	
	d) Forget to give a patient his medication on time	.52	
	f) Find that sometimes you have to leave tasks for the on-coming shift to complete	.55	
	a) Occasionally arrive late for work	.24	.68
PRIDE IN WORK	b) Sometimes stay on duty after your work shift has finished without payment	.12	
	c) Take special pride in completing tasks by set times	.12	.22

(In light of the correlational values in the above table it might be better to use only the items d, e and f in further analysis).

(b) Construct validity of the task/time orientation inventory

As alluded to in a previous chapter one way to check a construct's validity is to see if it is associated with another variable thought to be

related to it. In the present context there were no obvious contenders available to compare constructs with. However, it is reasoned that, in light of the increasing amount of tertiary educated students entering the profession, those newest to nursing may be less inclined to accept the status quo. To assess this contention the Pearson product-moment correlation was calculated between the variable "years in nursing" and FA 1 scores. Results indicate that the correlation between FA 1 and the variable (years in nursing) was in the direction predicted but was very modest (r = -.12).

Correlations between each of the individual items in the inventory (a-f) and number of years in nursing indicates that there is a modest negative correlation between the "occasionally arrive late for work" and "number of years in nursing" (r = -.15), thus giving tentative support for the notion that those newest to nursing worry less than "seasoned" staff about being occasionally late for work. Also, there was a little support for the contention that those newest to nursing are less concerned than older nurses about forgetting to give a patient his medication on time (r = -.20).

9.5 Discussion

That respondents subscribe to "task/time" imperatives is at least tentatively illustrated in the above findings. Respondents had very definite views on the issue as relatively few opted for the "It would depend category". Four of the six times in the questionnaire can be conceptualized as representing a singe factor - a "routine" dimension. These results are in keeping with popular anecdotal conceptions of the

nurse. It was seen above in Phase 1 that respondents alluded to working within strict "task/time" structures. Nurse theorists have also commented that nurses' work practices stress adherence to rigid protocols (Perry, 1986; Smythe, 1984; Walker, 1993).

There was tentative support for the notion that nurses newest to the profession subscribe less to the "routine" dimension of work compared to long-term staff. Perhaps, this reflects the fact that the socialisation process takes a little longer to occur than previously thought. Also, with more nurses entering the profession following tertiary education this may have affected newer nurses' more flexible approach at least in relation to arriving for work on time and the administration of medication to patients.

It should be noted that it is not intended to argue that subscription to, say, giving patients their medication on time, is not important or that being proud of completing tasks by set times is to be spurned. It is only when these are subscribed to with a rigid adherence that is questioned; thus ensuring strong resistance to possible alternative work practices. These may be more liberalising yet still achieving high quality nursing care and less disempowering work practices. An instance where strict adherence to longstanding work practices appeared to be hindering staff to thinking about alternatives is provided by the following account. In the psychiatry field it is often the case that nurses working in acute care wards see their patients only when an acute crisis arises. Once discharged, the patient is seen by community nurses. It is generally not possible for ward staff to follow-up their patients in the community. It would seem reasonable to suggest that both staff and patients may

benefit if nurses could organise their work so that they can spend time in the community and on the ward. Many patients have frequent admissions to hospitals, if staff worked in both locations they may better appreciate patients' circumstances and may be able to take proactive measures to reduce or avoid patient relapse; and patients, when admitted may find the transition easier as they will be well known by at least one nurse. It is not intended that the merits of this working practice be fully discussed here, rather the intention is to highlight the fact that when the above possibility was put to acute care staff where traditional work practices are adhered to such a notion was not considered a possibility, and some dismissed the idea out of hand. Another example was discussed above at Phase 1, where midwives who wanted to institute new work practices were met with hostility from colleagues who set out to thwart their actions, even to the extent of refusing to care for patients assigned to the "new" nursing care procedure. It would appear that an openness to alternative practice styles are stymied whenever work rules are adhered to rigidly.

The resistance to alternative views is not confined to nurses' clinical settings either. Within an Australian context, even nurse academics are cautious about criticising or exploring certain aspects of nursing culture. Alavi and Cattoni (1995) comment that it took them two years to write their paper which questioned current nursing practice because they were aware that "if one speaks critically or takes a questioning stance then one is positioned as disloyal, ungrateful and a bad nurse". Interestingly, these authors maintain that the shift from hospital-based courses to tertiary education for nurses will not alter the present practice of nurses,

once within the hospital setting, the culture will remain much as it always has been. They further contend that with the present education structure of nursing courses nursing will remain ghettoised within the university system.

In conclusion, accounts from respondents at Phase 1 suggest that nurses' work practices are responsible for creating an environment which precludes nurses thinking more creatively about how to organise their work in order to ameliorate the tensions that are inevitable in professional health care practice. Experimenting with different models of care delivery may be one solution to the creation of flexible working conditions and in turn allowing tolerance when new ideas are presented. However, any major changes in work practices will need to be carefully introduced, otherwise staff may feel threatened and as we have seen resist change when taken out of their "comfort zone".

Additional ideas on how an examination of nurses' work culture may provide further insights into the way in which staff aggression may be produced and maintained are contained in the final chapter under Future Research.

Finally, in future analysis using the above inventory items b and c and possibly a should be removed and other items chosen in an attempt to account for more of the variance with a one-factor solution. Alternatively, researchers may want to leave in place item c and experiment with other items to see if is possible to capture a pride in work dimension as suggested above. It is certainly conceivable that a task/time orientation

may include two dimensions - a commitment to routine, ie, getting the job done on time and a commitment to doing a good job, ie, taking pride in one's work. Once an appropriate scale is devised it could then be used to determine if subscription to a task/time imperative influenced the level of aggression in the workplace or influenced peoples' commitment of the *status quo*.

CHAPTER TEN

THE EFFECT OF HIERARCHY ON NURSES' BLAME PLACEMENT PREFERENCES

10.1 Introduction

When an incident of aggression arises the question of blame often gets asked. What reference points or social norms do nurses refer to when assigning blame to protagonists in an aggressive encounter. Recall, in Chapter 7, point 6, it was mooted that perceptions of an aggressive act may be affected by the job status of those involved in the encounter, in other words, hierarchy may be one source of explanation for determining who gets blamed for an encounter between staff. One way to examine the above notion would be to see if the same incident of aggressive behaviour between different grades of staff is assessed in the same way by nurses. Once a suitable aggressive incident is devised, we could ensure that like grades and unlike grades were assessed for their blameworthiness with respect to starting the same incident.

The main question asked is: Are nurses' perceptions of aggression swayed by protagonists' grades in determining blame placement?

To determine the effect of possible intervening variables respondents' age, years as a nurse and their current level of aggression experience will be examined to see to what extent they influence blame placement preferences. Recall, Lanza (1984b) noted that subjects' age and sex influenced their perception of blame placement when

asked to assign blame after reading a vignette about an assault experience between a nurse and a patient.

10.2 Development of video-taped scenario and accompanying questionnaire items

Because it is virtually impossible to predict when an aggressive encounter will occur it was deemed impractical and unethical to try and attempt to gauge nurses' reactions to a live encounter. Also, the fact that experimental control was required to ascertain the effects of independent variables on nurses' responses the study was conducted under "laboratory" conditions.

Upon reflection and discussion with colleagues the aggressive scene contrived revolved around the altercations between a staff member arriving late for work (negligence) and her subsequent "telling off" (intolerance) by a colleague. Based on anecdotal evidence and on my own experience of working both in Australia and overseas, it might be said that arriving on time for duty is one of the first "rules of conduct" a novice nurse learns and is something held dear by most nurses. The findings from the preceding chapter lend support to this contention too. Being "told off" can be seen as being a fairly typical response to frustration in the present context. However, to lend credibility to the situation where a junior nurse "tells off" a more senior grade, actors of similar ages were hired.

Two actors were hired to play the part of nurses. It was decided to use female actresses as the vast majority of nurses are female. Also, if males were included it would have meant undue complexity in

devising appropriate scenarios given the need for experimental control. In order to accommodate the three different job grades normally seen on hospital wards nine different scenes had to be "made" as per Appendix 3. The first scene involved an altercation between two Level-1 staff nurses. One nurse arrived for work late; on account of this the second nurse was delayed 15 minutes from going off duty. In each of the remaining eight scenes the altercation remained exactly the same but the *personae dramatis* changed, ie, as far as observers were concerned they were either watching two Level-1 nurses interact or a Level-1 nurse and a Level 2 and so. For illustration of the various scenes Figure 10.2.1 is presented below.

Figure 10.2.1 **The Nine Scenes Involving April and June**

		JUNE (Negligence, arrives 15 minutes late)		
		Level 1	Level 2	Level 3
APRIL (Intolerance - at being made to wait for June's arrival)	Level 1	SCENE 1	SCENE 2	SCENE 3
	Level 2	SCENE 4	SCENE 5	SCENE 6
	Level 3	SCENE 7	SCENE 8	SCENE 9

From the above figure it can be seen that, eg, the second scene depicts a Level-2 nurse interacting with a Level-1 nurse. The third scene involves a Level-3 and a Level-1 nurse, the fourth scene involves a Level-1 nurse interaction with a Level-2 nurse, and so on

until all three grades "play" each of the two different parts of "latecomer" and "being delayed". Each scene was observed by thirty respondents, who were randomly assigned to each scene. Respondents were then asked to apportion blame for starting the incident to each of the protagonists.

Blame was used in this instance to be synonymous with causality/ responsibility for starting an incident. The Concise Oxford Dictionary (1990) defines blame as the attribution of responsibility or censure for a bad result, wrong or error to a person etc., and that such culpability may be shared equally when more than one person is involved in an incident. Hence, respondents were asked to rate the extent that each of the parties involved in the aggressive encounter should be blamed for starting the altercation.

10.2.1 The major advantages and disadvantages of using a video-taped vignette to assess the influence of hierarchy on nurses' blame placement preferences

The major advantages and disadvantages of using a video-taped vignette are summarised below and are based on Lanza's (1986) and Flaskguard's (1979) ideas. First, a vignette has the advantage that the assault situation is standardised, ie, everyone responds to the same stimulus. There is more control over extraneous variables and it is possible to manipulate variables of interest and randomly assign participants to control and treatment groups - all of which are the requirements of an experimental design. In the present study it was important to use an experimental design so that cause and effect relationships could be demonstrated. Data can be gathered quickly

using this method and because of the immediacy of respondents' reactions to the aggression stimulus recall is usually not a problem. Any differences among respondents' responses can be interpreted as a reflection of individual bias and not an artefact of the vignette as each respondent has the same (aggressive) stimulus. Another advantage is that respondents' views can be ascertained prospectively, ie, before respondents encounter the "incident".

A major criticism of vignettes is that they are artificial and do not allow for accurate prediction of respondents' behaviour in live situations. It might be argued that video-taped vignettes will appear more real to respondents than written ones, although for both types there will always be an unknown area between one's response to the vignette and one's actual behaviour in a live encounter. However, in the area of communication skills training, it has been shown that "artificial" skills training can be effective in predicting trainees' future live performances (Crute,1986). While there will always be limitations with respect to the external validity of our research the nearer a vignette can get to the live situation the closer the gap will be between predicted and actual performance.

Lanza (1986) draws on the work of Flaskguard (1979) when she discusses how the internal validity of a vignette can be established in order to overcome some of its shortcomings. Firstly, the vignette's content validity should be established, ie, the degree to which the vignette mirrors a real situation. In the present study, it was important to devise an aggressive incident that was "real" for viewers and pertinent to a nursing context. The encounter had to a credible occurrence for each of the different nursing hierarchical levels within a

ward. As discussed above, it was decided to employ actors of similar age so that it would not seem too out of place for a Level 1 nurse to "tell off" a more senior grade and "time violation" was used as the kindling for the resultant aggression as it appears to be one of the first rules of conduct a new nurse learns when she begins work in the clinical setting.

Secondly, the scenario's credibility and questionnaire suitability was assessed by a panel of ten nurse colleagues who independently watched several different scenario versions. They were informed that they were evaluating a future research instrument. After each showing of a scenario their immediate reactions were sought on its realism, ie, the likelihood of a similar event happening in their work situation, the clarity of the questionnaire instructions, question order, ease of completion, and if they felt any questionnaire items should be deleted or new items added.

Eventually, one scene was adopted as being closest to reality bearing in mind the different levels of hierarchy that had to be accommodated. This scene was then shown to another panel of ten third-year student nurses - five nurses saw the version where the junior nurse was angry at the clinical nurse manager for arriving late, another five nurses watched the encounter between the two clinical nurse managers. It was thought that if these two versions, because of the juxtaposition of the nurses' ranks in each version, elicited variation in response rates among viewers it was likely that the others would too. A variety of responses were recorded for each of the two versions of the scene, therefore this scene was adopted for the study proper.

In an attempt to overcome the problem of artificiality during the testing process respondent views were collected in familiar surroundings, thus reducing the contrived nature of the experiment. For most respondents the study was conducted close to their work settings. Also, judging from respondents' comments following completion of the questionnaire, they appeared totally unaware that nine "different" scenes were being evaluated.

To assess the instrument's reliability (stability of response) ten nurses pretested the instrument twice. Each viewing was separated by one week. Pearson product-moment correlations were computed to assess individual respondent's agreement regarding their blame placement preferences for each of the protagonists.

10.2.2 The survey-embedded experiment

The survey format is a valuable tool in ascertaining baseline information as demonstrated above in Chapter 8 but it is very difficult to demonstrate causal attributions using this method. The experimental design on the other hand allows one to demonstrate the presence of one or more causal relationships between one or more dependent and independent variables. In this way, both internal and external validity should be enhanced. Singleton et al. (1988), Caltabiano (1989), Rossi and Wright (1984) and Grichting (1984) comment on the desirability of incorporating experimental designs in surveys. Caltabiano (1989) notes that an experimental design can control for threats to internal validity, such as maturation, testing, instrumentation, statistical regression selection, experimental mortality and selection-maturation interaction (after Campbell and Stanley,

1963). By incorporating the experiment within a survey and conducting data gathering in respondents' naturally occurring environments the artificiality of the experiment is mitigated. Whereas the experimental design can be seen as a highly controlled way of inferring causal relationships between one or more independent and dependent variables, the survey method can be used to obtain baseline data for the population of interest (Caltabiano, 1989). Surveys can be used for detailed exploration and description of existing phenomena (LoBiondo-Wood and Haber, 1990). By combining features from both experimental and survey designs, it is expected that internal and external validity be enhanced. Also, the survey-imbedded experiment is an attempt at removing the false dichotomy that has persisted in traditional research design (Caltabiano, 1989).

10.3 Procedure

Respondents were randomly assigned to each of the nine "different" vignettes. This was achieved by simply putting the questionnaires into 30 bundles of nine questionnaires each. Every bundle contained one questionnaire for each of the nine "different" vignettes. Each bundle was then "shuffled". As respondents were recruited into the study a questionnaire was taken from the top of the bundle in current use. This was continued until all 30 bundles of questionnaires had been administered.

10.4 Data analysis and results

A one-way analysis of variance was used to determine differences among respondents' estimation of blame for both April ("intolerance") and June ("negligence"), and to see to what extent each level or grade of nurse attracted blame regardless of the grade of nurse she interacted with.

To determine the effect of hierarchy on respondents' blame preferences a two-way analysis of variance was carried out.

To examine the influence of respondents' age, current levels of aggression experienced at work, and the number of years they spent as qualified nurses analyses of covariance were performed.

10.4.1 Stability of response

Table 10.4.1.1 **Correlations Between Nurses' First and Second Ratings of Blame Placement (n=10)**

CORRELATIONS

April	.72
June	.69

Table 10.4.1.1 indicates that nurses' were generally consistent in their blame placement scoring for April and June. Recall, 10 nurse

colleagues were asked to rewatch the same video clip of an interaction between April and June five days after their first viewing.

10.4.2 "Intolerance" versus "negligence"

Table 10.4.2.1 shows the distribution of blame assigned to April (the nurse who was delayed from going off duty - "intolerance") and June (the nurse who arrived late - "negligence") for each of the nine "different" scenarios. Inspection of this table indicates that June is blamed more than April on only one occasion. This occurs when both are depicted as Level-1 nurses, indicating that being late is a more punishable offence than the intolerance shown by a colleague when both are "junior" grades. Although, it should be pointed that this difference did not reach significance at $p = \leq .05$ using a one-way analysis of variance test (it is deemed appropriate to report probability levels here in light of the fact that this section reports on the experimental design results, ie, respondents were randomly assigned to each scenario).

Table 10.4.2.1 **The Mean Difference Between April's ("Intolerance") and June's("Negligence") Blame Scores**

		JUNE (Negligence - late)		
		Level 1	Level 2	Level 3
APRIL (Intolerance - delayed)	Level 1	-.40*	.30	.63
	Level 2	.73*	.87**	1.33**
	Level 3	.40	.47	.37

KEY: * June ("negligence") attracted a higher blame score than April ("intolerance").
** Significant difference between April's and June's blame scores at $p < .01$.

The above table shows that except in the case where June and April are both Level-1 grade nurses, June ("negligence") is always blamed less than April ("intolerance") regardless of what grade she is depicted at. Differences between grades were statistically significant when June, depicted as a Level-2 grade nurse interacted with a Level-2 nurse and when June as a Level-3 nurse interacted with a Level-2 nurse.

Examination of total blame scores were calculated separately for April and June to see to what extent each of their three levels/grades attracted blame regardless of the grade of nurse that they interacted with (Table 10.4.2.2). Scores obtained indicated that for showing "intolerance" April, as the Level-2 nurse, attracted most blame (total of mean blame scores = 13.11), followed by when she was depicted at the Level-3 nurse (total of mean blame scores = 12.00), with the Level-1 nurse being blamed least of all (total of mean scores = 11.43). Analysis of variance indicated that there was a significant difference between April's blame scores at Levels 1 and 2 (Table 10.4.2.3).

Table 10.4.2.2 **Blame Assigned to April ("intolerance") and June ("negligence")**

Scenario	mean blame scores		
Intolerance			Negligence
April (Level 1)	3.40	3.80	June (Level 1)*
April (Level 1)	3.90	3.60	June (Level 2)**
April (Level 1)	4.13	3.50	June (Level 3) ***
	11.43		
April (Level 2)	4.43	3.70	June (Level 1)*
April (Level 2)	4.30	3.43	June (Level 2) **
April (Level 2)	4.38	3.05	June (Level 3) ***
	13.11		
April (Level 3)	3.93	3.53	June (Level 1)*
April (Level 3)	4.10	3.63	June (Level 2)**
April (Level 3)	3.97	3.60	June (Level 3)***
	12.00		

Key: * = 11.03 (total blame score for June when Level 1)
** = 10.66 (total blame score for June when Level 2)
*** = 10.15 (total blame score for June when Level 3)

Table 10.4.2.3 Analysis of Variance (One-Way) for Blame Classified by April's Grade/Level

Source	SS	DF	MS	F	P
Between groups	15.702	2	7.851	3.995	.019
Within groups	524.769	267	1.965		
Total	540.471	269			

Further inspection of Table 10.4.2.2 indicates that June's total average blame scores when she is cast in the role of a Level-1 nurse is 11.03 (3.80 + 3.70 + 3.53), whereas when she is depicted as a Level-2 nurse her total average blame scores is 10.66, and when a Level-3 nurse 10.15. This result is in line with expectations - the more junior the nurse the more blameworthy she is with respect to arriving late for work, although these differences did not reach statistical significance at the .05 level.

10.4.3 The effect of hierarchy on respondents' blame placement preferences

To see to what extent hierarchy (grade of nurse - Levels 1-3) influenced perceptions of blame and to test for interaction between grades of protagonists and "blame factor", ie, "negligence" and "intolerance" the results for the two-way analysis of variance are presented in Table 10.4.3.1 and Figure 10.4.3.1 below. Two-way analysis of variance confirms that there is a significant main effect for April's ("Intolerance") grades ($F(2, 261) = 3.53$; $p = .03$) but not for June's ("negligence") ($F(2, 261) = 1.49$: $p = .23$); in other words, there

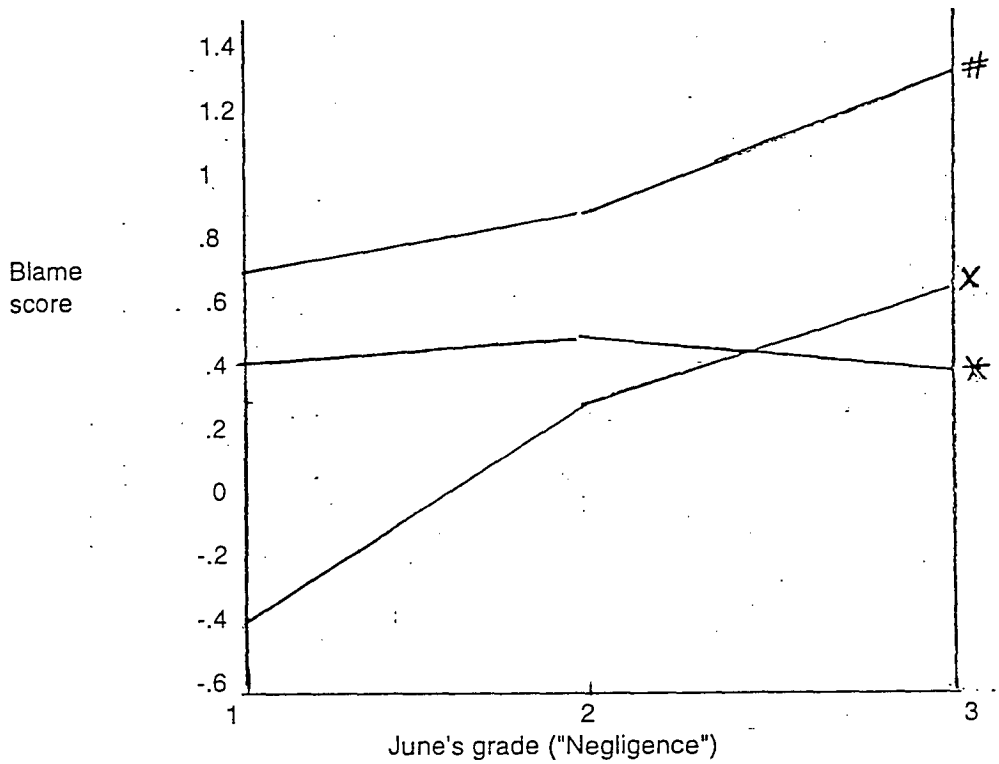
is only a significant relationship between April's blame scores and the composite blame scores.

Table 10.4.3.1 **Analysis of Variance (Two-Way) for Blame Verdict by Grade(Levels 1, 2 & 3) and "Blame Factor"("Intolerance" vs Negligence")**

Source of variation	SS	DF	MS	F	P
Grade	30.467	2	15.233	3.531	.031
"Blame factor"	12.876	2	6.433	1.491	.227
Grade X "Blame factor"	9.933	4	2.483	.576	.681
Explained	53.267	8	6.658	1.543	.142
Residual	1126.100	261	4.315		
Total	1179.367	269	4.384		

Although the Figure 10.4.3.1 below is suggestive of an interaction effect - April, as a Level-1 nurse is blamed progressively more for showing "intolerance" the higher the grades she interacts with; whereas when depicted at level 3 her blame scores are relatively stable regardless of who she interacts with - this was not statistically significant (F (4, 261) = .57: p = .68).

Figure 10.4.3.1 ANOVA Cell Means by Grades (Levels 1- 3) of April ("Intolerance") and June ("Negligence")



Key: x April depicted at Level-1
April depicted at Level-2
* April depicted at Level-3

Overall, the interpretation of these results is that there is a statistically significant difference between April's ("intolerance") blame scores; inspection of average composite scores indicates that the difference lies between April's Level-1 and Level-2 grades. April was blamed significantly more by respondents for starting the aggressive incident when she was depicted as a Level-2 nurse compared to when she was depicted as a Level-1 nurse. Also, April as a Level-2 nurse was blamed significantly more for starting the encounter when she interacted with either a Level-2 nurse or a Level-3 nurse. Because of

no significant interaction effects it appears that the difference blame scores were not influenced by the juxtaposition of the different nurse grades.

Separate analyses of covariance were performed to see if respondents' ages, the number of years they had been nursing, or their current level of aggression experience affected their blame placement. Inclusion of these variables resulted in only minor changes to the initial analysis of variance results, therefore indicating that these variable did not affect respondents' blame placement preferences.

10.5 Discussion

Respondents were, in the main, "persuaded" to assign blame for "Intolerance" rather than for "negligence" except in the case where both nurses were Level-1s, then it is the latecomer who is blamed more, although this latter result was not significant at the .05 level. Second, "intolerance" is particularly singled out for blame when the nurse is depicted at the Level-2 grade.

Taking each grade in turn, we find that when the Level-1 nurse is depicted as the nurse who is delayed ("intolerance") she is blamed more for starting the encounter except in the situation where the other nurse is also a Level-1 grade. The Level-1 nurse (when depicted as "intolerant") attracts more criticism the more senior the latecomer. However, these differences were not statistically significant. In the other situations, where the Level-1 nurse is depicted as the latecomer she is blamed less than the other grades who display "intolerance".

When the Level-2 nurse is depicted as being "intolerant" she is blamed more than any of the other grades for starting the encounter. In two situations - where she is interacting with another Level-2 nurse and a Level-3 nurse these differences are statistically significant. In general, the more senior the nurse she interacts with the more blame she attracts. In the other situations, where the Level-2 nurse is depicted as the latecomer ("negligence") she attracts less blame than the "intolerant" nurses.

When the Level-3 nurse is depicted as "intolerant" she is blamed more than the other nurses whom she interacts with. Where the Level-3 nurse is cast in the role of the latecomer ("negligent") she is blamed less compared to the other grades that she interacts with. However, this finding was not statistically significant, ie, the interaction effect failed to reach significance at the .05 level.

It was argued above (Chapter 4 and Chapter 9) that respondents were "wedded" to "task/time imperatives" why then are respondents swayed more by "intolerance" rather than by "negligence". It could be that the stimulus situation was too "strong" in favour of "intolerance". Also, it may be that respondents believe arriving fifteen minutes late for work is not a particularly punishable offence when it is juxtaposed with the behaviour of the nurse who showed "intolerance". Although not reaching significance, respondents deemed the latecomer ("negligence") to be more blameworthy when two Level 1 grades interacted. Perhaps, with a larger sample and a less aggressive response from "intolerance" this difference would be significant. If so, we might infer that blame placement is related to hierarchy and "offence".

That the Level-2 grade of nurse was blamed more than other grades for her "intolerance" was unexpected. Given that respondents were randomly assigned to vignettes and that the same person played all three Levels of the "intolerant" nurse it is likely that respondents are responding to the grade of the nurse rather than to the person playing the grade. In many nursing contexts the Level-2 grades are usually much fewer in number than the Level-1 grades. Level-2s normally have a supervisory role to play on the ward or unit. They may be seen by junior staff (in terms of grade, not necessarily in terms of age) as the bridge between them and the Level-3 nurse, in much the same way as the Level-3 grade is seen as the interface between management and clinical roles. In the day-to-day management of the ward, it is the Level-2 that is often called upon to direct care, (s)he may therefore have a more obvious role in the hierarchical structure for a majority of nurses. Also, when the Level-3 staff member is away responsibility for organising the shift normally falls to the Level-2 position. Therefore, in terms of face-to-face contact among the different grades of staff it is highly likely in most contexts that this will occur frequently between Level-1 grades and Level-2 grades. According to attributional theory literature, the more one supervises a person, the less you may come to trust in her/him (Lippa, 1990: 112). Presumably, the converse of this argument might hold too, ie, the more a person feels supervised, the more (s)he may come to dislike the supervisor. A majority of respondents were either at the Level-1 grade or were enrolled nurses - both grades likely to be supervised by a Level-2 nurse. Discussion with fellow clinically-based colleagues suggests that the newly qualified Level-1 nurse often values the contribution of a Level-2 nurse, however, nurses who have spent several years in nursing while remaining at the Level-1 grade may

resent the role of the Level-2 nurse. These nurses do not always see the need for a supervisor in the guise of the Level-2 grade, this is particularly apparent in institutions where the Level-1 nurse believes (s)he contributes as much as the Level-2 grade. In the present context, the current career structure has been in place for only a few years and it would appear that many Level-1 staff were not happy with the process of appointment to the Level-2 positions. Some colleagues have expressed the view that the Level-2 grade was given to "favourites" and that their current work performance doesn't warrant the extra salary (and kudos) that goes with the grade. Perhaps, it is this resentment that is being reflected in respondents' negative views of this position.

The fact that respondents were watching actors instead of "real" nurses in the vignette should not detract from their saliency for respondents. Attribution theory suggests that we generally typecast actors according to the roles they play, ie, we generally infer that actors' behaviours are part of their characters, not to the fact that they are playing a part (Lippa, 1990: 102 on Heider, 1958). The implication here is that there is a "carry over" effect from the clinical situation to the contrived one of the vignette. Thus, respondents can be seen to be evaluating according to their prejudices and not on the basis of the situation in hand. In effect, Level-2 nurses would appear to have a credibility problem. This may account for respondents' "bias" in their blame placement preferences; such "bias" perhaps only arises when respondents are confronted with a scene in which they have to choose between grades.

Theory-based insights contend that aggression in nursing is both generational and hierarchical, yet respondents in Phase 1 did not think that senior staff were any more aggressive towards them than their same rank colleagues. Are theorists wrong or are respondents a "skewed" sample? Perhaps, the answer is "no" to both questions. It is possible to accommodate both perspectives within an overall model of clinically-based aggression. It may be that the hierarchical nature of aggression between different grades of staff is only brought into sharp focus under certain circumstances. For example, we saw that respondents attested to instances of ill treatment and abuse when they first entered nursing. However, once across the "initiation" threshold it becomes difficult to differentiate aggression on the basis of rank as by then it is a feature that permeates all grades of staff. In the same way, without explicit prompting respondents' "biases" may not have been brought to the fore regarding their view of the role of the Level-2 nurse. It may be that the vignette can be seen as an instance of "sharp focus" for respondents - in this case they were faced with making a choice between grades for their blame placement. Neither the interviews nor the questionnaire items explicitly asked respondents about aggression between Level-1 nurses and Level-2 nurses, instead it concentrated on traditionally assumed "battle lines", ie, those between "junior" nurses (Levels-1 and 2s) and senior staff (Levels-3 and above). Without the benefit of "sharp focus" respondents may be "blind" to their biases. In the everyday social intercourse between staff, it may be that the cris-cross nature of aggression between ranks is better explained in terms of pecking orders between the Level-1 and the Level-2 ranks and not between the Level-3 grade and above and those below it. The fact that managers may bully junior staff is offset by junior staff's sabotage

of their plans and the squabbles that occur within their own ranks. So, perhaps, this is why managers are not seen as the more "nasty" grades, although, of course, the consequences for failing to "bend" to another's wishes may be more serious when a manager is involved than a colleague of similar rank. A staff member who is on a short-term contract is likely to be "respectful" of a manager's wishes if (s)he wants her contract renewed. In these situations where staff feel that their job is under threat it might be expected that hierarchical power will feature highly in nurses' minds. However, among nurses of similar rank there may be an imbalance in power relationships too. The threat of withdrawal of support can sometimes be a powerful inducement to "tag" along with another's wishes even though in different circumstances one may wish to distance oneself from that colleague. In the normally closer working relationship of the Level-1 and the Level-2 grades coupled with the inherent supervisor-supervisee relationship it may be here that nurses feel most concern about the position of the Level-2 grade. Of course a stronger case could have been made for the Level-2s' unpopularity if it was shown that this grade was also blamed more when depicted as the latecomer (ie, negligent) too.

Finally, the results suggest that the Level-1 grade is, overall, blamed least for showing "intolerance". Why might this be so? One possibility is that respondents, being mainly Level-1 nurses themselves, had more sympathy for the Level-1 nurse who behaved "intolerantly". There is evidence that we are more likely to blame our own shortcomings on external factors, eg, blaming our involvement in an automobile accident as a result of the other driver's inattention, whereas, another's failure is seen as reflecting internal dispositions,

ie, she crashed because she is a lousy driver (Lippa, 1990: 116). In the situation where respondents had to choose among similar grades to themselves perhaps they were swayed to excuse the intolerant behaviour of April (a nurse like themselves) on the basis of external dispositions, ie, on the fact that June was late.

In accounting for these results there are a number of considerations, some of which have already been alluded to above. First, it may be that the level of aggression shown by the nurse who was delayed was considered "over the top" by respondents and therefore mitigated any concern that they had about lateness. Second, because the effect of hierarchy was not as strong as was hoped for, it may be: a) hierarchy is not that important, b) it is important, however, the "over the top" "intolerant" response may have presented respondents with a *fait accompli* in terms of who to blame. The results from the last chapter help reinforce the view that the scenario was appropriate for a nursing context - that nurses do subscribe to a task/time imperative. A majority of respondents thought it was "bad" to arrive late for work. Therefore, the lack of an interaction effect between hierarchy and blame placement preferences may have arisen because nurses do not subscribe to a task/time imperative is not supported. To assess the contention that April's response was too "strong" a future experimental study could be undertaken where April's response is toned down or where June's misdemeanour is accentuated. Third, the administration procedure may have affected the results. On this latter point, every effort was taken to ensure that respondents were clearly briefed about completing the questionnaire and all questionnaires were completed in private. Also, respondents appeared to take the matter seriously judging by their comments of

support both before and after completion of the questionnaire. Data entry was undertaken by the author and every effort was made to ensure this was done correctly.

Having examined the nature of blame assignment it is important to focus on the directionality of aggressiveness. Is it one-directional or reciprocal? The findings from Phase 1 suggest that once aggression begins, for whatever reason, it tends to recur. This is particularly so in a nursing context where nurses where aggressive acts are allowed to go unchecked.

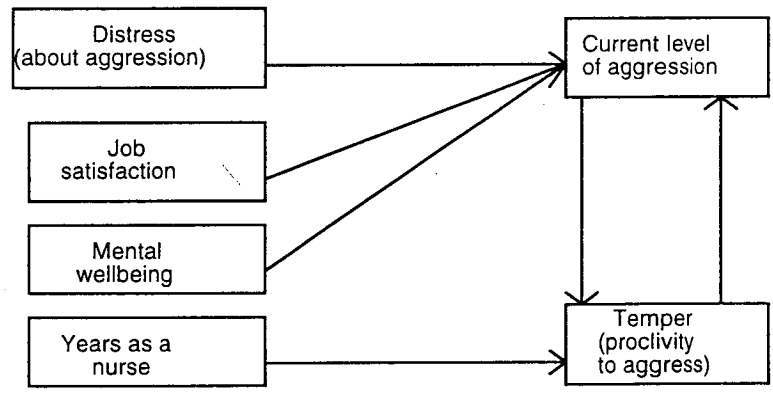
CHAPTER ELEVEN

AGGRESSION BREEDS AGGRESSION

11.1 Introduction

This chapter examines the extent of the relationships among the variables in the following model (Figure 11.1.1). In Chapter 7 a rationale for this model is provided. Essentially, the model indicates that workplace aggression can be conceptualised as self-maintaining, ie, once it arises (from whatever source) it is likely to recur, particularly in situations where it is allowed to go unchecked by nurse managers.

Figure 11.1.1 **Aggression Breeds Aggression**



The following hypotheses, which are part of the model in Figure 11.1.1, are tested:

1. Perceived current level of workplace aggression is modelled as a function of perceived workplace distress (on account of the individual's concern about aggression at work), job satisfaction, emotional well-being, and temper (proclivity to aggress).

2. Temper, in turn, is modelled as a function of current level of workplace aggression and number of years in nursing.

3. Perceived current level of workplace aggression is dependent on temper and vice versa, ie, the model is non-recursive.

It is expected that the following covariance relationships among the three exogenous variables will be as follows: the higher one's distress on account of aggression the lower one's job satisfaction; high levels of distress about workplace aggression will be associated with mental ill health. Greater mental ill health will be asscciated with lower job satisfaction.

Finally, as has been done in the previous chapter, for some variables comparisons will be made between women and men.

11.2 Measures

a) The temper test

It order to measure proclivity to aggress the temper test (TT) by London and Spielberger (1983) was used (Question 17, Appendix 4). This is one

of a number of tests devised by these authors to determine the role of stress and emotions in health and psychological problems. The test consists of a ten-item questionnaire in which respondents are asked to rate their response of: 1 Almost Never; 2 Sometimes; 3 Often; and 4 Almost Always to a series of statements, such as, I am quick tempered; I feel annoyed when I am not given recognition for doing good work and so on. Scoring is straightforward. The points, one to four, for each item are summed to get a total score. Test scores can be seen as representing a point on a continuum that ranges between low proclivity to aggress, ie, being unresponsive to situations that provoke stress and high proclivity to aggress, in other words, being a "hothead". A score below 13 indicates that people are generally unresponsive to situations that provoke stress. A score of 21 or above indicates the possibility of being a "hothead" - scoring higher than three-quarters of those tested (London and Spielberger, 1983). Note, these authors treat what are essentially ordinal scales as interval measures (the justification for this practice is referred to below at 11.3.7).

b) The General Health Questionnaire (GHQ)

To assess mental well-being the 12-item version of the General Health Questionnaire (Question 19, Appendix 4) was used (GHQ: Goldberg and Williams 1988). The GHQ is a well known self-administered screening test aimed at detecting psychiatric disorders among respondents in community settings and non-psychiatric clinical settings. It concerns itself with two main classes of phenomena: inability to carry out one's normal "healthy " functions and the appearance of new phenomena of a

distressing nature (Goldberg and Hillier, 1979). The GHQ has been extensively validated in a number of cultures and languages (Goodchild and Duncan-Jones, 1985). Essentially, the GHQ can be seen to represent a general measure of a person's likelihood of being a probable psychiatric "case", by providing a rough approximation of an individual's position on an underlying dimension of psychiatric illness. The higher a person's score on the test the greater likelihood that the person will be diagnosed with a mental disorder at an independent interview with a psychiatrist. When a dimensional model for psychological ill-health is used by researchers, the GHQ can be used as a proxy measure of an individual's position on the underlying dimension without becoming involved in the desirability or otherwise of declaring some individuals as "cases" and others not. The 12-item version of the questionnaire was chosen in preference to the longer 28, 30 or 60-item versions because of considerations of the overall length of the questionnaire. Also, the 12-item version has been shown to be as "sensitive" (the probability that a "true case" will be correctly identified by the test) if not more so than the other versions. In terms of its specificity (the probability that a true "normal" will be correctly identified), it performs about as well as the other versions. The test consists of 12 questions and respondents are offered four different choices for their answer. For instance, the first question - Have you recently been able to concentrate on whatever you're doing? - asks respondents to circle one of the following four answer categories: Better than usual; Same as Usual; Less than usual; Much less than usual. There are several methods of scoring the questionnaire, the more usual GHQ method of 0-0-1-1; simple Likert scoring (0-1-2-3), modified Likert (0,0,1,2) and the CGHQ scoring

method of Goodchild and Duncan-Jones (1985). In the latter method, test items are divided into those where agreement indicates illness (eg, feeling constantly under strain) and those where agreement indicates health (eg, enjoying day-to-day activities). The CGHQ method applies a score of one for those replying same as usual to any of the negative items. Both Likert and CGHQ methods tend to produce a less skewed distribution although the CGHQ provides a better prediction of caseness, ie, it gives a more accurate prediction of acute and chronic conditions, and is a more stable measure (Goodchild and Duncan-Jones, 1985). In the present study, the CGHQ scoring method is reported on.

c) Estimation of current experience of aggression

As before (Chapter 8), a single question asked respondents to rate their current experience of aggression at work on a six-point scale, where 1 signalled "None at all" and 6 indicated a "Daily" occurrence.

d) Distress about aggression at work

As before (Chapter 8), two questions assessed the extent of aggression as a distress factor at work. In order to avoid cuing individuals regarding what might be distressing for them it was left up to respondents to nominate a particular stressor or not as the case may have been. For those respondents who nominated aggression this was scored as ten. For those respondents nominating something other than aggression as their major source of workplace distress a supplementary question was included which asked them to compare aggression to their most

distressing concern. For this they were asked to rate aggression on a nine-point scale, where 1 indicated that aggression was hardly a concern and 9 indicated that aggression was almost as bad as their most distressing concern.

e) Job satisfaction

Question 28 asked respondents to rate on a six-point scale how strongly they agreed with the item: Considering everything, I am satisfied with my job at present; where 1 indicated strong disagreement for the item and 6 indicated strong agreement. Bruce and Blackburn (1992: 32) suggest that a single item asking about one's level of job satisfaction can provide a good overall indicator of employees' feelings about their job satisfaction.

f) Number of years as a nurse

Question 20 asked respondents to record the number of years they had been in nursing, including the number of years spent in nurse training and education (Chapter 7).

11.3 Data analysis and results

The model - aggression breeds aggression - was tested by means of structural equation modelling (SEM) using the Analysis of Moment Structures (AMOS) computer package.

11.3.1 Temper test (TT)

The mean TT score for respondents was 18.16; SD 4.38. Inspection of a histogram of respondents' scores indicates a leptokurtic curve (Kurtosis = 3.813 - indicating a distribution that is more peaked than normal). Approximately 58% of respondents registered scores in the "safe" zone (scores 18 or below). A quarter of respondents had scores 21 or above, indicating "hot headedness".

Internal consistency of nurses' reaction to temper test checklist indicates an alpha .78, well above the acceptable alpha range of .6 (Nunnally, 1978).

Women's (n = 229) and men's (n = 41) TT scores showed similar profiles with respect to the percentages registering scores 20 and below and 21 and above, indicating that each sex had about 25 % of their number registering scores in the "hothead" range. Women's TT scores were mean 18.14; SD 4.23; median 18: and for men: mean 18.36; SD 5.28; median 18.

11.3.2 General Health Questionnaire (CGHQ after Goodchild and Duncan-Jones))

Respondents' mean score for CGHQ was 4.83; SD 3.16. Taking a score of 5 to 6 as an indication of "caseness" between 36 and 48% of respondents had scores equal to or above these figures. These cut-off scores were calculated on the basis that GHQ scores for the 30-item test

suggests a 12 to 13 "caseness" score as opposed to a 4 to 5 "caseness" indicator using the more usual GHQ scoring method for the 30-item test. The reason for the higher cut-off score in the CGHQ test came about because of a different scoring method for 15 items, which had the effect of inflating the threshold by about eight points. In the 12-item test, six of these 15 items remained (ie, 40%) and as the normal cut-off score for the GHQ 12-item test is 2 to 3 it is proposed that these six items would raise this score by three points.

Internal consistency for the above test attained an alpha level of .88, well above the acceptable range and indicating a unidimensional scale.

Women's CGHQ scores were: mean 4.80; SD 2.17; median 4; and for men: mean 5.00; SD 2.99; median 5. When taking 5 to 6 as a cut-off score to indicate "caseness" both women and men have very similar percentages in the "caseness" category. Approximately 48% of women score 5 or higher, and 36% score 6 or more. For men the percentages for scores 5 and 6 were 51% and 38% respectively.

11.3.3 Estimation of current level of aggression

As in Chapter 6 the mean score obtained for nurses' current experience of aggression was 3.01; SD: 1.42 (n=266). Where 1 = no aggression experienced and 6 = aggression experienced daily. When frequencies are calculated for responses on this variable about half of the respondents are reporting relatively little experience of aggression in their current work while nearly 30 percent are reporting that they

experience aggression on a daily or near daily basis, ie, having a score of between four and six. Female and male respondents reported similar experiences.

11.3.4 Distress about aggression

For all respondents the mean score was 7.13, SD 3.12. This result indicates that aggression is a particularly distressing aspect for nurses at work.

11.3.5 Job satisfaction

The mean score for respondents on the job satisfaction variable was 4.30; SD 1.39. Approximately 71 percent of respondents had scores at five or six - indicating agreement for the item, ie, that they were satisfied. Approximately 29 percent of respondents had scores equal to or less than 3, indicating disagreement with the item.

11.3.6 Number of years as a nurse

The mean number of years that respondents had been in nursing was 15 years, SD 8 years.

11.3.7 Testing the model - Aggression breeds aggression

As in conventional regression analysis, the effects of exogenous variables are tested independently of the variances shared with other

variables. In conventional path analysis one variable is conceptualised as the dependent or endogenous variable and its variance is thought to be affected as a result of the combined effects of all the exogenous variables behind it in the model. Such a unidirectional model where no two variables in the model are reciprocally related allows one to use ordinary least squares regression analysis to obtain unbiased estimates of the model's coefficients. This approach is not appropriate in the present analysis. The above model assumes that two of the variables are reciprocally related (current level of aggression and temper/proclivity to aggress) with each being a direct cause of the other. Because of this complexity a non-recursive model is needed, where more than a single-equation model is necessary to determine the effects between variables.

It is to be expected that predictions will not be perfect however. For instance, the error associated with predicting temper as a result of workplace aggression and nurse years is a combination of random fluctuations in this variable due to measurement error as well as to all the other possible influences affecting one's temper which were not measured in this study. An error term is necessary as the model assumes to show *all* variables that affect one's perception of current level of aggression at work. Without the error term, the path diagram would make the implausible claim that current level of distress is an exact linear combination of the other variables. In effect, the error term serves to absorb random variation in a variable for which no suitable predictors were provided. An additional error term is needed for the variable - current level of aggression. The error terms associated with these variables were incorporated into the SEM model. In order to

ensure that the model is identified, ie, that we are able to make meaningful parameter estimates or in other words be able to infer the direction of causation between two variables, the error terms must be constrained. Normally this is done by fixing the path coefficient from the error term to the variable in question at unity.

Like conventional path analysis SEM evaluates the relative importance of various direct and indirect links between variables. A pictorial flow graph specifies the nature of the proposed model according to which the subsequent analysis is to be made (Figure 11.3.7.1).

SEM makes use of standardised regression coefficients, providing an index of the impact of each independent variable when the effects of other independent variables are held constant. Because the regression coefficients are standardised, we can compare the magnitudes from variable to variable. When used in a path analysis, they are called path coefficients. Since regression weights are used as path estimates in a SEM analytic model, the requirements necessary for multiple regression must be met. One prerequisite for multiple regression is that variables are either dichotomies or at least of interval nature. For purposes of analysis, the scores obtained on the variables: distress, current level of workplace aggression, the temper test, mental well-being and job satisfaction are treated as if they were interval level data. It is recognised that these measures may be simply estimating difference in degree (ordinal) as well as in kind (nominal). To overcome this difficulty one can either dichotomise these variables, ie, score them as "0" and "1", or simply accept them as they are while noting their ordinal level status.

The latter option was chosen for two reasons. Fundamentalists, according to Burns and Grove (1987: 290), subscribe to the notion that ordinal data can only be used in non-parametric analyses as equal intervals do not exist between the categories in these scales of measurement. They subscribe to Steven's' rules for assigning numbers to objects in a hierarchical order ranging from nominal (the lowest) through to ordinal, interval and ratio (the highest). However, a pragmatic position adopts the principle that many ordinal level scales, such as the ones referred to above, can have an underlying interval continuum and thus their use can be justified in parametric statistical analyses without serious consequences. Moreover, if Steven's rules are adhered to rigidly few if any measures in the social sciences could be classified at the interval level of measurement (Burns and Grove, 1987: 290). Second, when variables were dichotomised little difference in results were apparent. Another requirement for regression analysis is that a linear relationship exists between variables. Scattergrams indicated that there was no marked deviations from linearity. Regression analysis also requires an absence of multicollinearity. Table 11.3.7.1 presents the results of the Pearson product-moment correlational analysis undertaken to check for multicollinearity. All correlations are under .8 - the acceptable upper limit before multicollinearity is assumed (Lewis-Beck, 1980: 60).

Table 11.3.7.1 **Correlational Matrix of the Independent Variables Used in the SEM Analysis**

VARIABLE	1	2	3
1. Workdis			
2. Job satisfaction	-.16		
3. CGHQ	.14	-.38	
4. Nurse years	.02	.03	03

Table 11.3.7.2 shows means and standard deviations for each of the variables used in SEM analysis

Table 11.3.7.2 **Means and standardised deviations for the variables used in the SEM analysis**

VARIABLE	MEAN	S.D.
Distress	7.13	3.12
Current level of aggression	3.01	1.42
Temper (TT)	18.16	4.38
Mental well-being (CGHQ)	4.83	3.16
Job satisfaction	4.30	1.39
Nurse years	14.54	8.37

Table 11.3.7.3 shows the results for the regression weights and their accompanying standard errors and critical region estimates following the SEM analysis. Critical region estimates allow one to calculate probability levels when using a random sample.

Table 11.3.7.3 Regression Weights (Maximum Likelihood Estimates)

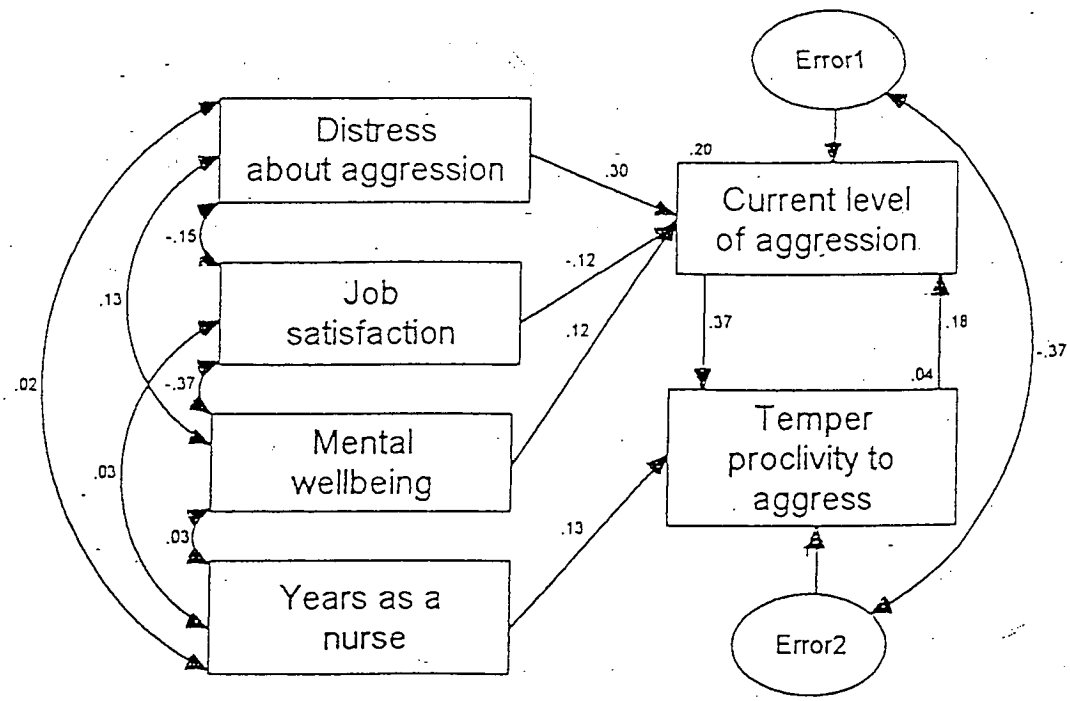
Regression weights	Estimate	SE	CR
Current level of agg'n<-----Distress	.14	.03	4.08*
Current level of agg<-------Jobsat	-.13	.06	- 2.10*
Current level of agg'n<------CGHQ	.06	.03	2.01*
Temper<----------Nyears	.07	.03	2.15*
Temper<-----Current level of agg'n	1.13	.45	2.51*
Current level of agg'n<-----Temper	.06	.13	.46

Key * Significant at P≤.05 (should a random sample have been used)

Figure 11.3.7.1 presents the standardised regression coefficients from the SEM analysis together with the zero order correlations of the relevant variables.

Figure 11.3.7.1 A Non-Recursive Model Illustrating the Impact of the Predictor Variables on Current Level of Agg'n and Temper

Model Fit:
CMIN/DF: 1599.20
BCC: 5249.74



Should this have been a random sample the goodness of fit estimates for the above model indicate a poor fit. The better the model fit the more plausible the model modifications seem. Suggestions as to why the model had a poor fit are explored below in the discussion section. However, the model is stable (stability index = .07). An unstable model (ie, with a stability index of equal to or greater than one) implies that the model is wrong, ie, it should not be modelled in its present form, or that the sample size is too small to provide accurate estimates of the regression weights (Arbuckle, 1995: 374).

The variance accounted for in current level of aggression and temper was 20 percent and 4 percent respectively. These are very modest amounts and indicate that these two variables are not very well accounted for by all the other variables in the model. Judging by the critical ratios (Table 11.3.7.3) the following hypothesis would be supported at conventional significance levels. (Probability estimates are reported for readers who are interested in ascertaining chance indices should respondents have been from a random sample).

Estimation of current level of aggression is dependent on workers' distress about aggression (critical ratio = 4.08); job satisfaction (critical ratio = 2.10); and mental well-being (critical ratio = 2.01).

There is also some evidence for suggesting that the greater the level of workplace aggression the higher nurses' temper levels/proclivity to aggress (critical ratio = 2.51) and the longer one has worked in nursing the greater one's temper (critical ratio = 2.15)

Perceived current level of workplace aggression does not depend on temper levels (critical ratio 0.46). This was an unexpected result. However, separate correlational analysis for these two variables indicates a positive association between them ($r = .22$, $p<.001$).

Correlations among the remaining variables, although modest, are in line with predictions: high levels of work distress about aggression are associated with low job satisfaction and an increase in mental ill health; and the lower one's job satisfaction the greater one's mental ill health.

11.4 Discussion

11.4.1 Nurses' temper levels

The indication that approximately 25 percent of this sample registered scores in the "hothead" category is similar to the results reported by London and Spielberger (1983) for this test. These authors conducted tests on a range of workers including, teachers, police and business executives. Nurses are, it seems, little different to other groups of workers in this respect. When women and men were compared on their Temper Test scores, both sexes had similar profiles with respect to the percentages of those falling into the "hothead" category.

11.4.2 Nurses' mental well-being

That a third or more respondents, whether female or male, had scores to put them into the "caseness" category, as measured by the CGHQ, is not too dissimilar to studies done elsewhere (Goldberg and Williams 1988:73). Parkes (1980) found that nearly a quarter of her sample of student nurses reported extremely high levels of distress, ie, they had scores greater than 12 on the GHQ-28! A later study by Parks (1982), using the 28 item version of the GHQ, found that among a group of student nurses (n = 164) the proportion of GHQ "cases" was 21.3%. Hunt (1989), using the 12-item version of the GHQ with Likert scoring, found that 28.8% of nurses had scores in the "caseness" category (although, Hunt's results should be treated with caution as the GHQ was not presented in identical form to the established GHQ 12). Among a community sample of women in Dundee, Hobbs et al. (1983) found a "caseness" rate of 30 percent and Benjamin et al. (1982) in Manchester found that 25 percent of their sample were "cases". In both of these studies younger populations were sampled.

11.4.3 Distress about aggression

Overall, aggregate scores indicate that aggression at work is particularly distressing for many nurses. Recall, in Chapter 8 nearly 50 percent of respondents indicated that aggression was their most distressing workplace concern. Of those nominating something other than aggression they indicated that aggression was an important distress factor for them too. Nurses not only have to cope with the inevitable

stresses and strains inherent in their job they also have to deal with aggression from colleagues and others to boot.

11.4.4 Nurses' job satisfaction

In relation to job satisfaction a majority of respondents indicated that they were satisfied with their work, however a sizeable proportion (29 percent) indicated job dissatisfaction. These results are in keeping with previous studies on job satisfaction among nurses (Gillies, 1989: 397). And in light of respondents' concerns about staff-on-staff aggression are perhaps to be expected. A major factor in workers' satisfaction at work is related to working in a cohesive environment where colleagues are supportive (Decker, 1985; Argyle and Henderson, 1985; Carr and Kazanowski, 1995;). Incidentally, these results suggest that nurses are reporting satisfaction levels a little lower than one would expect among professional workers who generally report the highest level of job satisfaction (Baron, 1986: 156) with 80 percent and above reporting job satisfaction (Argyle, 1989:234).

11.4.5 Aggression breeds aggression

The 20 percent of the variance in perception of current level of aggression and the 4 percent in temper accounted for by the model are small amounts. Ideally, one would like to see roughly equally strong paths between these two variables. However, these are not unusually low results by present standards. Results for regression analyses in

social science research typically account for modest amounts of variance (Grichting, 1979).

Overall, the findings from the SEM analysis indicate that: perceived high levels of aggression in the workplace are dependent on nurses' distress, their job satisfaction and emotional health; and high levels of workplace aggression lead to an increase in nurses' temper levels/proclivity to aggress. That aggression leads to resentment and anger in individuals to whom it is directed is in keeping with both the anecdotal and empirical evidence found in this study and elsewhere (eg, Chapter 8; Johnson, 1990). The model failed to support, on statistical grounds, the notion of a non-recursive relationship among these latter two variables, ie, current level of workplace aggression was not dependent on temper. However, the fact that aggression may be self-perpetuating is in line with the comments of respondents at Phase 1 where it was noted that aggression is allowed to go unchecked by nurse managers. Possible reasons for why the model was not fully supported are discussed below.

The finding that the longer respondents had been in nursing the greater their proclivity to aggress might reflect the fact that these nurses had become accustomed to working within an abrasive environment and had themselves succumbed to being a little more aggressive than those new to nursing. Smythe (1984) notes how "bitching", "griping" and other behaviours that serve to instil negativity at work can act like a contagion infecting both new and old staff. In such environments undermining of colleagues and hostility becomes the norm instead of team work and cooperation. Note, workers may stay on in such a situation not because

they like it but for the simple fact that there are few alternatives or that other factors of the job, eg, pay, compensate for poor staff relations.

The results from the covariance analyses, though modest, are in line with expectations. Perceived high levels of distress about aggression were associated with low scores on job satisfaction and high scores on mentall well-being (recall, a high CGHQ score indicates "caseness"). High scores on job satisfaction were associated with low scores on mental well-being.

In accounting for the fact that the model was not wholly supported (as indicated by model fit estimates and reflected in the modest amount of variances accounted for) there are several possibilities to consider. First, it may be that these results arose as an artefact of sampling, even though the sample was representative of Tasmanian nurses in general on a variety of indicators (Chapter 7).

A second possibility is that the theoretical formulation needs altering. Perhaps workplace aggression is so upsetting for some people that they seek to reduce it rather than engage in further aggression. For workers without this option, they may engage in passive resistance when aggression occurs, thus insulating themselves from further rises in their temper levels. At Phase 1, some respondents said that they had left settings which were high on aggression. Others were more resentful about the aggression that occurred in their work and while they did not go out of their way to foment it further, they were unlikely to behave in overly friendly or helpful ways towards those they saw as aggressive,

thus contributing to an unsupportive work environment. While the temper test employed above may be useful in tapping outward expressions of aggression, in retrospect, it probably fails to measure the more subtle and indirect expressions of aggression. More sensitive measures may be required for some of the other variables too.

While it is unlikely that the variable number of years as a nurse was seriously misrepresented by respondents or for that matter mental well-being, the measurement of job satisfaction and distress may benefit from more careful thought to their measurements. For instance, levels of job satisfaction may not be uniformly distributed across all aspects of work and work settings. A one-off general question about job satisfaction may overlook important aspects of this issue (Baron, 1986: 157). Moreover, the literature on job satisfaction among human service workers is still in its infancy, we do not have a clear picture about what the important issues are to consider (McNeely, 1992: 226).

Additionally, one or more predictor variables might have been excluded from the model, indicating the need for a broader searching effort. There is the possibility that the omitted variable(s) may be correlated with both the dependent and one or more of the independent variables in the present model. In such a situation the path coefficients in the model might be substantially affected even to the extent of reducing to zero some of the now non-zero coefficients, and of reasserting causal linkages estimated as zero in the present model (Blalock, 1971: 47). Neff (1985: 265) acknowledges that the unexpectedly weak causal effects in studies on work behaviour points to its enormous complexity

and its manifestly interactional character. This author underscores the importance of acknowledging the importance of the "psychological baggage" (ie, work personality) that individuals bring to their work environment. Thus, to ensure that all relevant moderating and intervening variables are included in a model would require an understanding of the total work environment and individuals' work personalities.

That alternative specifications of the model (not reported above) failed to elicit a clear cut advantage in terms of interpretability and/or variance accounted for lends further support to the suggestion that additional research is needed to determine the relationship between temper and current level of workplace aggression.

Notwithstanding the above, these results and the findings from the previous chapters help to reinforce the view that staff-on-staff aggression is a major factor in nurses' work situations and is likely to continue unless decisive action is taken to reduce it. Action can occur at the individual or at the structural level and be aimed at the primary, secondary and tertiary level of intervention. In primary intervention the aim is to reduce the risk factors that produce aggression, eg, environmental stressors at work; in secondary intervention the aim is to alter the way in which individuals respond to stressors that lead them to react with aggression. Finally, tertiary intervention is for individuals who have been traumatised or distressed at work. as a result of workplace aggression (Quick et al., 1992:10). The final chapter explores some specific ideas about how some of these interventions may be put into practice.

CHAPTER TWELVE

RECOMMENDATIONS AND FUTURE RESEARCH

> Work is, by its very nature, about violence - to the spirit as well as to the body. It is about ulcers as well as accidents, about shouting matches as well as fist fights, about nervous breakdowns as well as kicking the dog around. It is above all (or beneath all), about daily humiliations. To survive the day is triumph enough for the walking wounded among the great many of us" (Studs Terkel, 1977: 1).

12.1 Introduction

While work may provide many of us with "daily meaning as well as daily bread" it can have a downside too (Bruce and Blackburn 1992: 4). Studs Terkel's comments above are apt for many of the nurses in this study. A major concern of respondents in the present study was staff-on-staff aggression. The situation was so bad for some that they sought work elsewhere. While nursing has generally been regarded as a vocation or a "calling" and those entering the profession are normally, committed, enthusiastic and caring, however, when confronted with the stresses inherent in the job - for instance, the sometimes life and death decisions that have to be made, the inability to return the aggression meted out by clients or their relatives and unsupportive colleagues to boot - it is not surprising that ideals become soured, or as a colleague recently put it,

"They can do what they want and say what they like so long as it (the job) pays the bills".

For this person, nursing had become just another job, it had little to offer him, his disillusionment and the bitterness he felt towards fellow colleagues and his nurse manager was tolerable only so long as his pay check arrived every fortnight. Nursing had not turned out to be what he had expected when he was 18.

This chapter provides an overall summation of the findings from Phase 1 and Phase 2 and offers for consideration some recommendations about how the workplace can be less "aggressive" and become more in tune with workers' needs. Finally, ideas for future research are discussed.

12.2 The main findings revisited

Overall, the main findings can be summarised thus: nurses' understanding of the term "aggression" encompasses a range of behaviours and attitudes that can be conceptualized along three dimensions: physical-verbal; active-passive; and direct-indirect. A definition of aggression was provided - to deliberately cause psychological or physical harm to another through verbal and non-verbal acts. Such acts may be direct or indirect and be active or passive. This is very much in line with the typology above, however, within a nursing context this definition is almost exclusively reserved for nurse colleagues. Patients aggressive behaviour was generally excusable because of factors beyond their control In practical terms, this aggression was

played out in such behaviours as rudeness, abusive remarks, undermining another's ideas, refusing to help when needed and, more rarely, actual physical threat and assault. Much of the aggression can be seen as colleagues' failure to play by the relationship rules of work. The majority of respondents at Phase 1 indicated that aggression from colleagues is a major concern for them.

This view was largely confirmed in the lager sample at Phase 2. A conservative estimate indicates that as many as one-third of all respondents at Phase 2 cite aggression from colleagues as either their *most* or one of their most important workplace stressors. Estimation of the frequency of aggression indicates that nearly 30 percent of respondents experience aggression (mainly in the form of rudeness, abusive language, humiliation and so forth) on a daily or near daily basis. Taken together, colleagues, doctors, and non-nurse managers come under fire in many different work settings. Thus, nurses not only have to cope with busy demanding work environments, many have to work alongside difficult colleagues too.

Overall, nurses' reactions to aggression can be seen in terms of three main response patterns: a stress response, an anger response, and a reflective response. The most popular as well as the most helpful action taken by respondents following incidents was to talk with a colleague. Many respondents also sought professional help which perhaps indicates the seriousness of the aggression they experienced. The least helpful action was talking with a manager or keeping it to oneself. Nurse

managers were generally regarded as unhelpful by respondents at Phase 1 - in effect they avoided acting on staff concerns.

About a quarter of respondents had temper scores in the "hothead" category. In terms of their mental health, about a third fell into the "caseness" category for mental illness.

Female and male nurses had similar views about the level of colleague aggression towards them. However, following colleague aggression, women were more concerned about aggression from patients' relatives and doctors, men had most trouble dealing with the aggression from their nurse managers.

The suggestion that many respondents are wedded to a task/time perspective was generally supported. Relatively few chose the option "it would depend" when asked a number of questions about the need to complete tasks on time (Chapter 9). These results lend support for the view that nurses' concern with completing tasks by set times stymies the adoption of alternative and ultimately more productive responses when faced with the inevitable challenges inherent in any work setting.

There was little support for the notion that hierarchy influences blame placement preferences for deciding who should be blamed for an incident. However, the Level-2 nurse attracted more blame than either the Level-1 or the Level-3 grade for reacting aggressively towards a colleague who was late. It would appear that the Level-2 grade of nurse has a credibility gap vis-a-vis fellow colleagues.

In accounting for aggression between colleagues a few main issues were addressed. These included feminist writers who generally subscribe to the notion of nurses being an oppressed group and because of this they react angrily towards each other - a case of anger turned inwards at the group level. Other views suggest that it is the practice of nursing itself that is at fault. Where the work itself is distressing, where staff do not value their own contribution, where they do not have appropriate release mechanisms to vent their frustration and anger it is, perhaps, not too surprising that in these situations, nurses may turn their anger on to colleagues and others nearby. Many respondents in Phase 1 attested to the lack of formal debriefing sessions at work even following major incidents. Therefore, organization structures such as disenfranchising workplace practices (as in subscription to a task/time imperative) including a management system that "allows" staff conflict to persist may be used to account for poor peer relations too. In these circumstances, once begun aggression may continue for the simple fact that it is seen as part of the job, and novice nurses are socialized into a prevailing culture where abuse and undermining of fellow workers is commonplace. In line with this argument comes the notion of aggression being self-perpetuating, ie, aggression breeds aggression. However, on statistical grounds, the notion of a reciprocal relationship between temper and current level of aggression was not supported. There was some evidence for supporting the notion though that one's temper levels (proclivity to aggress) are dependent on the years one had been in nursing and on the current level of aggression (at work). This result was in keeping with some of the views expressed in Phase two where some respondents alluded to the fact that older nurses more than younger

nurses were responsible for the aggression they received and that aggression at work made them angry and resentful of those they perceived as being aggressive.

12.3 Study Limitations

The main limitation in the present study is lack of a random sample of nurses appropriate in number to adequately represent nurses from different levels in the organisation and from different practice settings. For example, few nurse managers took part in the present study and nurses working in paediatric wards or drug and alcohol units were few too. On the positive side however, there is support for thinking that the results overall are tapping nurses' important concerns. Anecdotal literature in nursing attest to poor staff relations and the recent literature from the business community indicate that staff relations at work are a major concern. In the present study, the results from two distinct methodologies concur - the findings of the survey were in broad agreement with the views of those who had been interviewed on many major issues thus lending further credibility for the study.

There is the possibility that some respondents were swayed in their answers by a social desirability bias, ie, they were reluctant to deviate too much from what is expected of nurses. This is perhaps only a slight possibility in the present study when one considers the candour of respondents for other parts of the questionnaire. Also, respondents independently and privately completed the inventory thereby reducing the need to disguise their "real" views.

The failure to clearly demonstrate that hierarchy affected blame placement preferences was discussed in Chapter 10. In a nutshell, the theoretical model may have been wrong and/or the response from the nurse who had been delayed may have been "over the top".

Similarly, the theoretical model proposed to account for aggression as self-perpetuating may also require reformulation. As well, more sensitive measures may be required for some of the variables (see discussion Chapter 11).

12.4 Implications for practice

It is paradoxical that in a discipline that has "caring" as its main focus employee relationships were found in this study to be so poor. An essential element in providing nursing care is one that emphasizes partnership and interdependence within and between professional groups yet the picture painted by respondents is of seriously impaired staff relations to the point where some feared physical assault. The buzz words of today "empowerment" (of patients), "quality care" and TQM (total quality management) and so forth are likely to ring hollow without a concomitant concern for staff needs. It is difficult to imagine any sustained improvement in services when staff feel unsupported and resentment towards one another. Also, when tensions are high staff are unlikely to perform at their best. At work as at home there may be impaired personal relationships, work performance may be reduced, errors and accidents may increase, and the person may go off sick or

leave the organization altogether (Jenkins, 1992), thus compounding the situation further.

There is of course a danger in painting the picture too black by extrapolating from the views of the "average" nurse to all nurses. A couple of respondents during Phase 1 remarked that it was the behaviour of one or two staff that caused them most concern, and made life a misery for themselves and many others. In nursing as elsewhere there are examples where staff have very friendly relationships with one another. Also, staff may not be aware of how their behaviour affects others that they interact with. Ryan and Oestreich (1991: 6) in studying intimidation by managers, suggest that managers are generally unaware that their behaviour evokes fear among employees. These authors note that in situations where there is mistrust and fear a small amount of intimidation can be magnified so that a little bit of fear goes a long way. In relation to worker-on-worker conflict it is easy to see a parallel situation.

Not withstanding the above, the present findings point to a worrying level of staff-on-staff aggression and conflict and should in no way lead to complacency about the need for affirmative action. Staff in a range of clinical settings in both the private and public sectors are voicing their concern. If we are to take their views seriously, the aphorism "she'll be right, mate" will not be a good enough response in the present circumstances. Moreover, since the study began the author is personally aware of a number of situations where staff have either left their present employment or gone on stress leave as a result of lack of support from

their colleagues or their middle and senior managers. While we may not have all the answers to make the work environment "good" that is no reason to ignore the problem.

12.5 Recommendations

Before making any recommendations it should be recognised that nurses share many problems unique to human service professions. The potential problems inherent for workers in hospitals need to be taken into consideration too. These were addressed in Chapter 1 and included the fact that working with or on people has the capacity for fuelling staff conflict. Also, the advent of managerialism within the health care setting means that the emphasis has shifted from service to cost containment and staff tenure is no longer a given in many jobs. Moreover, the present findings point to an inherent volatility among nurses (as in other workers). Recall, about a quarter of respondents fell into the hothead" category when assessed on proclivity to aggress, and about a third of respondents registered scores in the "caseness" category for mental illness. All in all, the potential for conflict among nurses would seem to be high. Indeed, given the constraints that nurses work under it is, perhaps, hardly surprising that staff relations are poor. Both managers and workers have to recognise that a combined effort is needed if long-term "good" working conditions are to prevail.

It is important that an integrated organization-clinical approach is implemented to improve staff relations. Patford (1990: 264), drawing on the work of Benner (1984) and Murphy (1988), notes that the

indiscriminate application of stress-management techniques are unlikely to have much relevance for workers who are bored, disengaged or already overtly intent on the maintenance of control. Similarly, anger management programs that focus exclusively on teaching individuals how to control their own aggression will not be an appropriate response for individuals who have to return to an environment where colleagues are hostile and managers fail to recognise the individual needs of staff.

The recommendations outlined below are of two kinds: those that require an immediate response on account of the most pressing findings, and those more general suggestions about management style and individual responsibility that are likely to take a longer time to materialize.

12.5.1 Recommendations for immediate action

i) That both workers and nurse managers recognise that a problem in staff relations exists

Nurses at all levels in the hierarchy have to wake up to the fact that a problem exists. Recall, at Phase 1 some senior nurses became defensive when asked about debriefing sessions for staff and in Phase 2 the longer nurses had been in the job the greater their likelihood to fly off the handle. Somehow, the cycle of aggression has to be broken. The longer a dispute rages the harder it will be to make amends. Admitting that a problem exists is probably the single most useful strategy towards reconciliation. At one level, it is hardly news that colleagues can be difficult or even aggressive to work with, yet in the case of nursing as

elsewhere, this notion has almost been totally ignored publicly. Admitting that a problem may exist, however, may be problematic when it is seen as a sign of failure. Just as individuals may feel that backing down is a sign of weakness and loss of face, managers too, may feel reluctant to admit that all is not well with their employees - what manager wants it known that her/his unit has difficult staff relations. A manager's defensive reaction to staff difficulties was seen recently when a nurse manager remarked to the author how difficult it was to attract staff to work in her unit; the fact that many staff had recently left had not prompted her to ask why they didn't want to stay. During the course of this study what has become clear following conversations with nurses from a range of clinical settings is the extent that aggressive behaviour is allowed to go unchecked by management and that when individual staff complain there is little in the way of support from either nurse managers or non-nurse managers. A sense of frustration caused by the inaction of those perceived to be in a position to make changes can best describe nurses' feelings.

ii) That nursing management endorse policies that stress good staff relations

Bassman (1992: 167) suggests values are the foundation of organizational culture. Just as there are policies on sexual harassment and smoking and so forth there should be an organisational ethos that stresses good employee relations. For instance, IBM has a statement about everything being done in a way to affirm the dignity of the individual. Recall, at Phase 1 one respondent intimated that her

colleagues weren't clear about what their role was in relation to offering professional care. Adopting the co-worker rules outlined in Chapter 3 may be a start in this process. How senior management articulate these values influences how employees are treated in the organisation. Instilling positive and empowering behaviour among employees is unlikely to materialise where managers hold low opinions about their employees and have policies that seek to stress staff control rather than encourage initiative. Moreover, it is often from nurse managers that junior staff take their cues about what is and is not acceptable behaviour in the work place. Many respondents complained both about colleague aggressiveness and their manager's refusal to get too involved when incidents occurred. In essence the message is sent that staff issues are not that important for managers to care about.

While one's values generally show through in one's deeds, organizational values can also be reinforced through written communication to all employees. Further discussion about how managers may foster cohesiveness within the organisation are discussed below under "structural considerations"

iii) That interdisciplinary meetings be set up to review working relationships

It is clear that nurses, along with other health care staff, work in fairly unique circumstances where teamwork and interdisciplinary support is usually necessary for the delivery of effective care. The increasing specialization of nurses and the concomitant blurring of roles between

disciplines make the need for clear and respectful communication among professions a necessity if good relations are to prevail in the clinical setting. From discussion with respondents and staff more generally, few departments have interdisciplinary meetings that focus on establishing good working relationships.

iv) That an immediate review of nurses working in isolated settings be set up

There is evidence from this study and other anecdotal information that nurses working in rural and remote regions feel particularly vulnerable as a result of aggression from clients and others (Grainger, 1996). For all nurses working in isolated settings whether classed as urban, rural or remote the back-up facilities and support offered to them should be investigated.

iv) That union representatives acknowledge the plight of workers

Unions, as a matter of urgency, should commission a report into the scale of the problem for all their members, including nurses and ancillary staff.

That unions insist that policies are in place in the organisation on employee relations. It is important that unions highlight their own official policy about how they expect employees to be treated and they each other. Unions can play an important role in structuring members' views on aggression at work. They can help shape workers' views

regarding managers' and workers' rights and responsibilities in the workplace. A joint union-management initiative could be embarked upon.

v) That the staff counselling service be relocated to an area that is easily accessible to all staff. That all staff are made aware of the service offered

Respondents indicated that contact with the hospital staff counsellor is mainly through self-referral. One might be forgiven for thinking that the status of the counsellor is held in low esteem by the hospital management where the most of the respondents were recruited. Her office has recently been relocated, at short notice, from a convenient area within the main hospital complex to a rather depressing location across the road and some distance from the hospital. Formerly, she had direct informal contact with staff on a daily basis. These were useful times in which to chat with staff and take soundings about current issues. These chance meetings sometimes had an added spin-off in that they avoided the necessity for staff to see her on a formal basis. Now, easy access to staff has all but disappeared.

vi) The personnel and other departments where employees take their complaints to respond quickly and decisively to try and effect resolution

Some respondents became frustrated by what they perceived as a general lack of urgency by those to whom they complained.

vi) That nurse managers seriously reconsider their roles in relation to staff relations

Clearly, there is a case, based on the present results, for suggesting that nurse managers are unclear about their roles in relation to facilitating good staff relations. While individual nurses can make important decisions about how they relate with colleagues nurse managers are needed to influence the pace of change. If nurse managers do not take the lead in facilitating good peer relations and continue to avoid involvement in staff disputes bullying and intimidation amongst staff is likely to continue.

vii) That exit interviews be established for all staff prior to them leaving the organisation. And that the results of these interviews form part of the organization's annual report.

Just as patient questionnaires can help staff obtain a measure of their quality of care, staff exit interviews can provide managers with a picture, among other things, of their organization's interpersonal health. Additionally, employees could be given a questionnaire to complete where anonymity of responses is assured.

viii) That training courses in aggression management in nurses' clinical settings include a module on staff-on-staff aggression.

The findings from this study provide ample evidence for suggesting that courses that do not consider staff concerns vis-a-vis their colleagues and

others are omitting an important concern of nurses. More generally, it is likely that management of patient aggression will be more effective where staff relations are good. Some specific ideas on how staff including nurse managers can strive to make the work environment "good" are contained in the discussion below.

11.5.2 Recommendations for the long term

Earlier it was suggested that novice nurses are quickly socialized into the dominant social structures of nursing. It was also suggested that this does not mean that nurses should accept that they are so constrained by their culture that change is impossible. In sociology, the debate surrounding the importance of agency and structure has been around for many decades. In essence, the debate stresses on the one hand that sociology should concern itself with understanding the influence of social structures as *the* determining factors in an individual's behaviour (Durkheim, 1964). On the other hand, there is the argument that places emphasis on the way individuals create and recreate their social world (Weber, 1965). A third view acknowledges the dialectical process by which individuals give meaning to their world. This view suggests that the "theoretical views of Weber and Durkheim can be combined into a comprehensive theory of social action that does not lose the inner logic of either" (Berger and Luckman, 1966: 207). Berger and Luckman maintain that individuals create the world in which they live and work, but in so doing their world becomes institutionalized or turned into social structures, which in turn limits their actions (Abercrombie et al., 1984). The relevance for these views in the present context is that without an

acknowledgment of the importance of both structural and individual factors in the production of staff-on-staff aggression attempts to reduce it will ultimately fail.

a) Structural considerations

It is worth remembering that work can be a rich source of personal fulfilment, contributing to a worker's psychological health, socioeconomic improvement and physical health (Corey and Wolf, 1992: 64). It is axiomatic that staff relations are bound up more generally with an organisation's principles and practices regarding employee relationships. For those companies with low incidence of worker stress claims recent study findings suggest that they had supportive work and family policies, effective management communication, health insurance coverage for mental illness and chemical dependency and employee assistance programmes (Shalowitz, 1991 cited in Corey and Wolf, 1992: 362). Corey and Wolf (1992) add that the above perhaps implies the influence of another primary variable: an employer's value placed on employee wellness. In the context of staff-on-staff aggression managers can be seen as having the potential to greatly influence relations amongst staff.

It is recognised that some nurse managers may feel they have an impossible job: on the one hand they are being harangued often at the behest of non-nurse managers to implement cost containment measures (by, eg, non renewal of employee contracts, allowing a time lag between staff leaving and recruitment of new staff, cut backs on overtime and so forth) and on the other hand they are expected to foster harmonious

working relations among staff and maintain an effective service. In the present climate, where balancing the books is the catch cry of government, where efficiency seems to be stressed at the expense of quality, now, more than ever nurse managers need to develop a culture that places worker relations at the forefront of their endeavours. We saw above that when workers are distressed with their job there was a negative spin-off in terms of their proclivity to aggress. It is likely that abrasive staff relations will have knock-on effects for patient care too. Cary Cherniss describes how new staff in the process of coming to terms with the stresses and frustrations of their work began to change and they became less caring and committed as time went on. It might be expected that where there is high staff-on-staff conflict this will be a major contributor to nurses' "burnout" over and above any inherent stress associated with the job. From my observations and comments made by some of the respondents at Phase 1 it would appear that the candle for some staff is glowing dimly on account of poor staff relations. The costs associated with stress leave and job resignation help to compound the issue further. In one local unit there has been a 100 percent turnaround in staff over a one-year period. For some of those who left, poor staff-management relations was a significant factor affecting their decision to leave. Thus, poor staff relations are likely to have important impacts on workers, patients and the organisation. Managers, at all levels in the organisation, have to take responsibility for factoring in staff relations as one of their main responsibilities - "...if managers were to focus on the financial costs of their employees it might be possible to pursue more flexible, imaginative, and futuristic personnel policies..." (Cooper, 1987

and in Chapter 1: 5). In the next section discussion centres on how managers can be effective in facilitating good staff relations.

i) Shared system of management

Within a nursing context it is the nurse manager's task to plan, organize, direct, and control available financial, material and human resources so as to provide the most effective care possible to patients and their families (Gillies, 1989:1). Corey and Wolf (1992: 68) contend that managers have a powerful, if not direct effect on the health of employees too. Indeed, they go so far as to state that this contention is not a matter of professional dispute. These authors acknowledge the primary role of the manager as a resource person to employees in carrying out their respective roles. They propose an integrative approach for managing breakdown in the "mutual accommodation process" between worker and manager. The mutual accommodation process refers to the day-to-day interaction between employee and employer (or manager or supervisor). In healthy interactions there is give and take between both parties and each support the other in an attempt to reduce conflict and achieve common aims. When the mutual accommodation process collapses employee and employer are alienated from each other and there is an increase in worker stress claims, client complaints of poor service, employee theft and general antagonism between employee and employer. In the context of the present study there appears to be a breakdown in the mutual accommodation process between workers themselves as well as a feeling of disenchantment with managers' inaction to their concerns.

Corey and Wolf refer to their management model as MBR - a proprietary trademarked name for a management system entitled Management by Resources. This management model emphasizes management's responsibility for identifying risk factors at work. For instance, Sauter et al. (1990) identify six psychosocial risk factors - work load and work pace, work schedule, role stressors, career security factors, interpersonal relations, and job content. Cox and Kuk (1992) suggest that worker problems in six different aspects of organizations may be related to worker stress and psychological ill health, these are: organisational culture, the management and social environment, communication, the task environment, the problem-solving environment, and the staff development environment. Similar concerns were distress factors for respondents in this study, although worry about poor colleague relations was a major concern for many staff. Recall, about a third of staff indicated that aggression from colleagues was the most distressing aspect of their work.

Managers are also trained to clearly articulate role clarity for themselves and their employees and to be accountable to employees for maintaining productive and healthy relationships with employees. Education of all employees, including first-line managers in the basic tenets of MBR is emphasized. Corey and Wolf suggest that the adoption of management systems that emphasise human worth and dignity, that reject the traditional role of "boss knows best" in favour of models that emphasise the supportive role of management. Where managers provide resources for employees to think for themselves, counsel workers and so forth will produce results similar to MBR. Findings from Phase 1 point to few

opportunities for staff to air their views about how to create better staff relations. Even when major incidents of aggression arose respondents complained that few nurse managers enquired about their welfare. Perhaps, this lack of management initiative reflects the low priority given to management in nursing in Australia where there is little in the way of formal management training required of those who attain managerial positions either at unit level or further up the hierarchical ladder. More generally, management training in Australia trails that of other "developed" countries (Karpin, 1995).

Where employees are concerned about aggressive colleagues (or other issues) managers can be proactive in facilitating discussions amongst staff so that grievances can be aired. The views of workers at all levels in the hierarchy should be sought about how to create better working conditions. Regular staff seminars, perhaps, run jointly by nurse managers and members of the staff development team will help underline the importance that managers attach to these issues. This will help communicate to staff that their concerns are too important to be fobbed off to others to address. To ensure the success of these initiatives, staff need to be assured that they will not be penalized for speaking honestly. Recall, in Phase 1 some respondents feared speaking out lest it affected their future career. Just as workers may fear repercussions if they voice concern, managers may fear hearing "bad news", particularly if they lack the skills to bring about change. Start small and go slowly is the advice from Ryan and Oestreich (1992: 118) to managers in these situations. They suggest managers focus initially on the fear of speaking up. An unstructured meeting is probably best to

begin with so that staff feel free to air what for them are the important issues. Managers can get a feel for the atmosphere among colleagues by paying attention to how workers engage interpersonally with each other. A manager can be on the look out for instances of put down, insults or uncooperative work practice between colleagues. Where a manager's initial introductions on the topic goes flat, Ryan and Oestreich (1992: 119) suggest that this may reflect the fact that there is something about the manager's own behaviour that may be intimidating to workers.

There may be occasions where a nurse's communication style is a major factor in fomenting disruptive peer relations. However, it should be remembered that nurses in general aren't inherently any more aggressive than other groups of workers (Chapter 11). Therefore, reasons for staff-on-staff conflict should not focus exclusively on people's inherent aggressive characteristics or shortcomings. A better tactic is to focus on the positive aspects of their contribution to work. Cherniss (1995) suggests that professional employees want to feel that what they do makes a difference in other people's lives; they want to be intellectually challenged; they want autonomy; a supportive work setting; a recognition for work well done, and so forth. A pervasive finding among workers at Phase 1 was the lack of supportive culture between themselves and nurse colleagues including their nurse managers. The tall poppy syndrome and its fallout "squashed weeds" (Cox, 1996: 62) continue to dominate the nursing landscape at work.

Recall, at Phase 1 some senior staff became a little defensive when asked about their follow-up activities for their staff following incidents of

aggression. Subsequently, when discussing aspects of this project with some senior colleagues, nurse managers included, I sometimes met with a wall of defensiveness. My questions were taken as criticisms. So conscious was I of this that I began to preface my remarks to them with "I'm only asking a question. I want to try and understand the situation...". These responses can be seen as another example of self-serving bias (Chapter 4). Without being too analytical, it seems they had succumbed to Freud's notion of projection. The fault lay with others, the system or whatever, they had no responsibility to bear for it. Where managers want to influence change among employees (and themselves) Ryan and Oestreich (1992: 115) list a range of skills required, these are:

* demonstrate that you are listening, eg, pay attention to words being spoken and the emotion conveyed;
* serve as a role model for the behaviours you want others to emulate, eg , work at eliminating abrasive behaviour personally;
* be an initiator, eg, take the lead in turning fear into trust;
* be open to feedback - be willing to acknowledge deficits in your own behaviour - reward rather than shoot the messenger;
* be willing to make personal changes - be open to adjusting personal behaviour as a result of feedback;
* be vigilant - stay in touch with the work environment;
* deal with your own fear of speaking up - use your own experience to learn about and appreciate the vulnerabilities of others;
* facilitate rather than direct, discussions and meetings - be a catalyst for others' discussion and reflection;
* take a developmental, learning-orientated approach - see the

experience of reducing fear and anger as a way to create new insights for yourself and others;

* bring in outside consultants - when you feel you are in over your head with interpersonal or group dynamics, seek the services of an outside consultant.

On this latter point, Witte (1973, cited in Hofstede, 1991: 200), a German researcher, suggests that successful change in an organization's practices requires the joint action of two parties: a Machtpromoter and a Fachpromoter; in English, a power holder and an expert. In order to avoid compromising either of these roles Witte suggests that they should not be the responsibility of a single individual. The Fachpromoter's role is to provide insight into an organization's cultural orientation and work practices; with this sound diagnostic information the Machtpromoter can make decisions about the various strengths and weaknesses in the current organisational setting, about the need for organisational change, about the resources needed to bring about successful innovation, about her/his crucial role and lasting role in the change process and so forth (Hofstede, 1991 : 201).

Note, there is a danger that by bringing in outside help workers may become resentful. Where workers are not consulted on the need to utilize expert help they may mistrust management's motives and feel that they are being "set up". In times of economic stringency, staff may fear that their job is on the line. Recall, in Phase 1 some respondents were critical of the use of short-term contracts. They feared speaking up for fear of losing their job.

The above ideas must be tempered with the realization that primary interventions at work in the form of task or job redesign or modifications of the organisational structure are likely to produce stress in some workers. Change, even where it is designed to be positive places new demands on workers. Change made at one level in the organization may have unintended and negative impacts at another level (Campbell Quick et al., 1992). Rosen (1989 cited in Corey and Wolf, 1992: 74) notes "that excessive, poorly managed change can make people sick". Recall, in Phase 1, the introduction of new work practices for mothers in labour let to resistance and hostility. To help ensure that change has a positive outcome it is important that staff are prepared for them in advance.

ii) Proactive employee assistance programmes

Employee Assistance Programmes (EAPs) can be seen as a tertiary intervention for stress management and are particularly popular in the United States (Cooper and Payne, 1992: 349). Essentially, they act as a safety net by providing counselling for employees suffering from occupation and/or personal distress. Most employees problems can be treated within the context of a brief therapy model. Corey and Wolf recommend that there be no limits to the number of times an employee makes use of the EAP service. Also, they see a role for members of an EAP to personally contact employees who are seen at risk of developing adverse reactions as a result of noxious work conditions (or personal difficulties). Looked at like this EAPs are an adjunct to self-referral. To facilitate management's awareness of workers' concerns, clinicians

involved in EAP programmes can share non-privileged information with management. Recall, in the context of the present study, the staff counsellor was relocated at short notice to a distant part of the hospital complex. It would seem hospital managers are not worried that this move may signal to employees that the staff counsellor role is not seen as all that important by management.

However, it should be recognised that EAPs may not be welcomed by all employees, especially those who are reluctant to acknowledge that they are under stress. In the United States there is a much greater degree of acceptance of mental illness compared to European countries. This is perhaps reflected in the fact that far fewer EAP programmes are available in European organizations (Cooper and Payne, 1992: 351). Where workers are weary of EAPs management can seek their views about alternative avenues by which workers may seek support.

EAPs and other tertiary programmes may also provide information to workers (and managers) about a range of personal stress reduction techniques, such as, self-monitoring, relaxation exercises, cognitive coping strategies, time management and so on. Measures specific to anger management and negotiation skills can also be included within these programmes.

iii) Focus on person-environment fit

Staff can be asked for their opinions about possible changed working conditions. Occupational stress can occur as a result of a mismatch

between what the worker wants from a job and what the job can supply. Many nurses are wedded to a task/time imperative and there appears little room for experimentation with other models of service delivery. In nursing, the idea of flexitime and self-scheduling may be an option to consider for some staff. These management options can contribute to nurse satisfaction and reduce staff turnover (Wulff, 1994: 265).

Corey and Wolf suggest that clinical psychologists through learning about workers' concerns from EAPs can assist organisational psychologists to devise appropriate screening methods to ensure the right employees are selected for the particular jobs on hand. However, as job requirements can change it is important that the organization implements on-going training and staff development programmes to ensure that the person-environment fit be maintained. In nursing there can be rapid changes in the use of technology and managerial imperatives that may make formerly prized skills and attributes redundant. In situations where there is an employee shortage, managers will be limited in their choice of who they employ, therefore, to ensure that the organisational ethos is maintained regular staff development programmes would seem to be essential in these circumstances.

iv) Rapid response to work injury claims

One goal of EAPs is to help ensure that employees' psychological problems do not become claims for disability. Nevertheless it is likely some employees will file claims for compensation as a result of work

stress, to report an injury or to gain specialized treatment. Whenever a claim is made, Corey and Wolf strongly endorse a rapid and substantive response by management, ie, one that tries to understand the condition and its treatment. These authors maintain that when managers are seen to be caring in this way workers get the message that they too are important to the organization.

The above points to what nurse managers can do to promote good employee relations. However, it should be noted that just as managers themselves may sell themselves short with respect to realizing their impact on staff relations, nurses, at all levels in the hierarchy, may not always see the relevance of the manager's role. Robinson and O'Connell (1995) clearly show the negativity associated with managerial roles in nursing. Following the implementation of a new career stream at ward level which was designed to give experienced nurses recognition of their knowledge and skill, clinical staff questioned the legitimacy of the role where it related to managerial duties. Those appointed to the new positions tended to devalue the importance of this aspect of their new role too. In essence, both groups of nurses were wedded to the notion that "clinical practice is what nursing is all about" (p. 133). Robinson and O'Connell note that the lack of institutional support afforded the new appointees suggests a lack of awareness by those who devised the new role about the "powerful imperatives that drive nursing culture". These authors note that, those new to the career structure were given an impossible task - on the one hand they were expected to maintain a clinical role and at the same time take on a range of new responsibilities with little guidance or tangible support - a recipe guaranteed to cause the

role's demise. They stress the importance of clearly articulating the management role to all concerned as well as providing institutional supports to make the new role a success. Nelson and Fells (1989) recognise that in the task-orientated hospital environment these facts may be overlooked even though poor interpersonal relations among staff are a significant cause of work-related grievances and occupy a considerable amount of staff time. These authors note that the development of good staff interaction needs to be built into a nurse manager's role.

b) Individual considerations: the role of the employee in disturbing the "stagnant quo"

Many of the ideas outlined above surrounding the skills required by managers will of course be useful for individual employees to adopt too. Just as managers may need to change their assumptions about their behaviour so too may employees. And being supportive of colleagues is as much a worker responsibility as that of management. The important contribution of individual employees to facilitate productive peer relations should be recognised. All employees have a responsibility for making work "good". While managers have a vital role to play in facilitating good relations amongst staff their efforts are likely to fail without the goodwill of workers.

In accounting for the maintenance of negative attitudes, constant complaining, "bitching" and so forth among nurses Smythe (1984) refers to this as the "stagnant quo" - a negative variation of the *status quo*

where stagnation occurs whenever corrective input and change are absent. In such circumstances "the group norm of the staff becomes one of maintaining the familiar - even if the familiar happens to be disruptive, malfunctional or purposeless. After all human beings are creatures of habit, and even bad habits can feel safe and familiar" (p. 208). When new staff come along they are quickly "infected" by the pessimism and defeatism of the seasoned staff who maintain they have seen it all before and it didn't work then either. In similar fashion, some of the respondents in the present study spoke of the negative attitudes of staff and how easily it was to become a target if one didn't fit in/conform to the ward culture or to the norms of a particular group or clique. On discussing the project with colleagues, it was sometimes difficult for the researcher not to get sucked into a negative spiral of recrimination and pessimism. Like aggression (Chapter, 11), negativity can be self-perpetuating too.

Sometimes a simple change in our behaviour may be all that is needed to foster more productive working relations. This point was brought home to the author when a colleague remarked on the positive effect on relations between herself and secretarial staff in her department when she decided to start the day by greeting the secretaries with a cheery "Good morning". Within a very short time this greeting was reciprocated and there was an added spin-off - requests from this colleague were met with a greater willingness to respond by these staff. The next example illustrates how our written communication may negate harmonious work relationships. During data collection for Phase 2 a dressing trolley with the following "order" scribbled on it was parked in the room where

respondents were completing the questionnaires: "Doctors, clean the trolley after you use it". Presumably, nurses need to be reminded to clean up after they have used the trolley too, yet the note targets doctors only. Not surprising therefore that doctors may resent the implied rebuke. Also, some doctors may feel, rightly or wrongly, that cleaning trolleys is not part of their work. The above are but two specific incidents about how in small ways the "aggressive" atmosphere in units can be lessened or maintained by simple communication acts.

Devoting as much time to the effects our own behaviour may have on others as we do to complaining about others' interpersonal behaviour would tip the balance in favour of critical self reflection and pave the way for the establishment of productive relations. Seeing colleagues simply as "nasty" individuals, as many respondents thought about those whom they labelled aggressive, denies them the opportunity to ever be seen in a positive light. It also helps distance the labeller from the part (s)he may have to play in the encounter. When that happens, we duck out of taking responsibility for making work "good'.

Implicit in the above view is that we can choose to behave differently if we want to. This notion is also the cornerstone of the anger management techniques put forward in the writings of Albert Ellis (1989), Novaco (1985) and others. Ellis asserts that some people choose to overreact to the obnoxious behaviour of others while they could more wisely choose to react in a very different manner. Specific anger management techniques may be warranted for those who believe they have a problem managing their own anger and aggression. Some respondents alluded to

the fact that one or two staff could be particularly "difficult". More generally, staff development workshops could focus on aggression management skills for employees. In the local context, what workshops there are on aggression management almost exclusively focuses on managing clients who have become aggressive. In the case of the local context, considerable sums of money have been spent on bringing in outside facilitators to teach staff on one particular unit about how to manage patient aggression. Yet, the major problem on this unit is not patient aggression but poor staff relations, as evidenced in the unit's staff turnover rates, from personal observation, and staff remarks.

In conclusion, seeing poor colleague relationships simply as symptoms of nursing's marginalised status in an environment that subscribes to mainly masculine ideals which support aggressiveness, competitiveness and dominance over others instead of cooperation underestimates the complexity of individual interactions among groups. Eva Cox (1996), in the context of a feminist perspective, rejects the argument that we can simply lump all of women's woes on men. Cox suggests that we see ourselves through our relationships with others. She continues "...this puts the responsibility on each of us to act ethically and protect others where necessary" (p. 46). Within the nursing context, Smythe (1984) and Kohnke (1881) seem to be in unison in urging all nurses to recognise their own complicity in the process of denying colleagues a "good" work environment. Offering colleagues support and understanding is one of the key ways in which workers can help one another. Strong support systems can be an effective buffer to stress. Recall, in Phase 2 speaking with a colleague was the most frequent

response following an aggressive incident. It was also the most helpful action.

12.6 Facilitating creative tension in the workplace

The above points should not be taken that aggression or tension in the workplace are necessarily bad. This notion was addressed in Chapter 5 where it was suggested that conflict may encourage competition and performance, as well as help bring issues out into the open so that resolutions can be attempted. These ideas are elaborated on here. There is a danger that in our attempts to develop conducive staff relations we endeavour to stamp out or suppress all conflict and in so doing we merely swap one "stagnant quo" for another one - where critique, innovation and change are treated as threats.

In light of the inherent volatility in any work force, for instance, recall about a quarter of respondents fell into the "hot headed" category, it seems inevitable that colleagues will rub one another up the wrong way. Levinson (1978 cited in Sutherland and Cooper, 1988: 19) suggests that some individuals in an organisation are prone to cause others stress by their failure to recognise the sensibilities and feelings of others. This author labels such individuals "abrasive personalities". Also, it is worth remembering that nurses do not work within a vacuum, nursing is not insulated from tensions associated with political imperatives and inter-professional and intra-professional rivalries. Recall, in Chapter 8 nurses' distress factors at work included colleague aggression, workload pressures, disagreement with physicians and so forth. On a wider front,

some current tensions surround the debates over cost containment and the delivery of quality care, the jurisdictions of doctors over nurses' roles, the educational preparation of nurses and so on. Nurses' traditional response to such conflicts has been "prevention at all costs" (Johnson, 1994: 643). It might be argued that not to speak out on these issues is failing in one's role as a professional nurse. However, in business organizations and in nursing conflict or even polite critical inquiry carry a stigma (Alavi and Cattoni, 1995; Pascale, 1990). As alluded to earlier, Alavi and Cattoni (1995) suggest that those who adopt a questioning stance in nursing are seen as disloyal, ungrateful and bad nurses. And some respondents in the present study voiced their concern at speaking out, in particular those on short-term contracts. Nurses in general are socialized into accepting "taken for granted" rules and rituals and not to question the *status quo.* The results from Chapter 9 on nurses' subscription to task/time imperatives lend support for this view. According to Robinson (1995 on Street, 1995) the nursing culture is suspicious of critique and fosters a "tyranny of niceness" which avoids confronting or even acknowledging that problems may exist.

The task of management and individual employees is not to suppress the expression of tensions but to learn how to manage organisational conflict to produce constructive outcomes. Pascale (1990) suggests that it is the failure of companies to harness conflict and tensions within their organizations that has caused many previously successful companies to fail. Failure in this sense, refers to profitability and market share. Similarly, one might argue that when professional public service organizations do not harness the inevitable tensions that exist within

them they fail too, ie, in the sense of being sensitive to their patients' needs, making use of new technology, devising innovative treatment techniques, experimenting with shift rosters and flexible working conditions and so forth. Pascale (1990) suggests that "inquiry (persistent questioning) is the engine of vitality and self-renewal and that the ultimate, and largely ignored, task of management is the creating and breaking of paradigms (dominant mind sets)" (p. 14). Robinson (1995) outlines a Participatory Action Research (PAR) programme designed to help nurses engage in debate surrounding the taken for granted aspects of their practice. In essence, nurses are encouraged to become critical observers of their own behaviours and to question their role vis-a-vis other disciplines. Any effort that increases nurses' engagement with their practice and fosters collaborative problem-solving is to be welcomed. However, a critique which concentrates solely on exploring nurses' marginalisation as a result of dominant medical regimes of control may distance nurses from a concern about how they themselves may contribute to their own problems. Cox (1996) notes that while women "may not have caused many of the problems they face, they must nevertheless take responsibility for finding solutions". She urges her readers to "move the debate from the idea that women are simply and unilaterally oppressed by men..." (p. 26). Similarly, in the context of staff-on-staff aggression the debate needs to be shifted beyond a preoccupation with oppression theory.

12.7 Future research

In Chapters 9, 10, & 11 suggestions for further research were alluded to regarding the inclusion of other variables to the "task/time" inventory, the effect of hierarchy on nurses' blame placement and the "aggression breeds aggression" model. The following ideas for further research suggest some more follow-up options, viz:

a) Research with random samples of nurses from both public and private hospitals to ascertain if the present findings are corroborated. The present study contained mainly public sector employees and used a convenience sample of nurses.

b) The effect of the organisational culture on staff-on-staff conflict

It is likely that a fuller understanding of staff-on-staff conflict will entail a close consideration of the organization culture of the work environment, including factors which, singly or in combination, elicit poor staff relations. We saw above that nurses behave in ways that help maintain the *status quo* of their work practices and along with it poor peer relations. Many nurse managers allow workplace aggression to go unchecked and nurses in general subscribe to a task/time imperative. Other interesting work on the nature of organisational culture has been reported by Hofstede (1991). This too may throw light on how nurses' values and work practices may help sustain staff-on-staff conflict. Hofstede discovered five consistent cultural differences on values across countries: to wit power distance; collectivism versus individualism;

femininity versus masculinity; uncertainty avoidance, and long-term versus short-term gratification of needs - this last dimension was added following research done in China. Within countries however organizations may be separated on different practice orientations. At the practice level organizations can be categorized on at least six dimensions namely: process orientated versus results orientated, employee orientated versus job orientated; parochial versus professional, open system versus closed system, loose control versus tight control, and normative versus pragmatic. A consideration of one dimension and one value orientation illustrates how they may have relevance for understanding staff-on-staff aggression. The dimension - process orientated versus results - opposes a concern with means (process orientated) to a concern with goals (results orientated). In the results-orientated culture employees are comfortable in unfamiliar situations and put in maximal effort, with each day bringing new challenges. In a process-orientated culture people avoid risks and make only a limited effort in their jobs, with each day pretty much the same. In his study Hofstede found that the firm scoring highest on results was an airline company, whereas the most process orientated setting was the production unit in a pharmaceuticals company. It would appear nursing culture straddles both ends of this dimension at once. While nursing espouses the qualitative aspect of attending to patients' needs (process dimension), there is also the contradictory orientation to a task/time imperative - to get things done on time (results dimension). Staff subscribing to different orientations are likely to be in conflict with each other. Where individuals subscribe to a process orientation but feel compelled to practice a results orientation conflict within the individual

might be expected too, which in turn may affect a worker's interpersonal relations. More subtly, Cooper and Payne (1992: 363) illustrate the way in which a caring orientation may lead to a tolerance of aggressive staff behaviour. In an organization that leans towards the high femininity end of the value orientation some of its main characteristics are that it values caring for others and preservation, people and warm relations are important, people are supposed to be modest, both men and women are allowed to be tender and to be concerned with relationships, everyone should have sympathy for the weak, stress and conflict should be resolved by compromise and negotiation etc. Putting people down, trying to be too clever or showing off will be regarded as inappropriate behaviour. However, taking strong decisive action to those who transgress the culture's social norms runs counter to a "feminine" perspective. Thus, aggressive behaviour may be allowed to continue for some time before decisive action is taken by the collective. Thus far, it appears that Hofstede's work or the ideas of Cooper and Payne have not been applied to a nursing clinical setting in a public sector organization. Currently, nurse authors use the word culture in an indeterminate way. Incorporating the ideas of the above authors in studies of nursing work would be a major step forward in articulating a cultural perceptive within a nursing context. Salient aspects of an organization's culture could be determined through a range of qualitative and quantitative techniques, including participant observation, semi-structured interviews and pencil and paper techniques.

c) The effect of management training on fostering good staff relations. If the laments above about the lack of and the need for

management training for nurse managers are to hold much weight a study should be conducted which assesses the effects of management training on staff relations. Staff relations in units or wards where nurse managers have had formal training in management practices could be compared to those where nurse managers have little or no formal training. Ideally, such a study would also disentangle the effects of management style from the effects of formal management training.

d) The long-term effects on the mental and physical well-being of staff who work in areas where there is unwanted stress as a result of staff conflict

Just as Puckett and Cleak (1994) suggest that it is possible that the cumulative effects of client abuse and threat contributes to staff burnout as much as the other stresses inherent in responding to clients' often insoluble problems, the effect of staff-on-staff conflict should be assessed too. Although respondents in the present study indicated a range of stress-like reactions it was not possible to determine if these were short or long-term responses. Staff could be interviewed prior to and shortly after beginning work and then followed-up at regular intervals over a number of years. Cherniss (1995) interviewed a group of human service employees shortly after they began work and again ten years later. This study provides fascinating insights into how many of these staff coped with burnout. Interviewing staff regularly would help avoid problems with recall of information for participants. In the Cherniss study many of the people contacted for the second interview didn't

remember the original study where they had been interviewed but took it on faith that they had been in it (p. 11).

e) The effect of staff conflict on patient care

A couple of respondents alluded to poor work relationships as well as "improper" handling of patients when they worked in nursing homes. Questions on patient care could be incorporated in the interviews in the study outlined above.

The above two study suggestions raise an ethical concern. Where staff are found to work in situations where there is high staff-on-staff conflict or where respondents report patient maltreatment researchers are put in a dilemma - if the study is allowed to continue in order to get further "hard evidence" the researcher may be seen to be inadvertently condoning such practices for her/his own private gain. Of course, what is acceptable "evidence" in studies is a moot point. Nevertheless, researchers have to be cognisant of this issue so that they can counter the argument that they would be better employed in research projects that seek to facilitate good staff and patient relations.

f) Proper evaluation of intervention programmes designed to reduce staff-on-staff conflict

Intervention can be costly in terms of time and money and it is vital that they be carefully evaluated. As a first step, staff can be asked for their views on how to make the workplace better. Both qualitative and

quantitative data could be gathered to monitor the effects of programmes over an extended period of time using an action research methodology.

g) At the individual level, exploration of the influence of environmental factors on staff's appraisal and reaction to workplace aggression

We saw above where workers were distressed as a result of workplace aggression this, in turn, affected their proclivity to aggress. Given that some degree of tension and conflict are perhaps inevitable in most work settings it is imperative that research is devoted to an investigation on the individual's appraisal of events. Patford (1990) notes that individual responses in terms of cognitive appraisals of events are governed by cultural norms, values and role expectations. And that "individual susceptibility to social cues will be especially strong when situational ambiguity is high" (p.281). In line with this theorizing, it might be expected where there are clear policies and guidelines on work issues including workplace aggression individual stress responses to staff conflict will be reduced.

h) Comparative and longitudinal studies of a greater range of human service workers and workers in other fields is urged by Patford (1990: 282) in relation to studies on stress - similarly, studies are required to situate staff-on-staff conflict so that the plight of these workers and the setting of reform priorities have a comparable data base

While the literature on understanding aggression among workers is highly complex and bedevilled by methodological difficulties, ultimately,

careful, committed longitudinal investigations involving qualitative and quantitative approaches are likely to yield the most fruitful results.

Finally, this study points to a major source of stress for employees - staff-on-staff conflict. Sutherland and Cooper (1988: 32) note that stress in the workplace poses a serious threat to individual well-being and ultimately to organisational survival. Similar to these authors' comments about the need for continued research on stress, research must continue to highlight the circumstances surrounding occupational conflict among employees too, so that remedial action can be put in place and preventive measures planned to make work and the workplace the ideal that Studs Terkel (1977: 1) highlights in his acclaimed book *Working*,

> It is about a search, too, for daily meaning as well as daily bread, for recognition as well as cash, for astonishment rather than torpor; in short, for a sort of life rather than a Monday through Friday sort of living.

Appendices

Appendix 1: Questionnaire for University Respondents

Nurses' Experience of Aggression in the Workplace

I am conducting research into nurses' experience of aggression while at work. As a first step into this inquiry, I am seeking the views of nurses from a variety of work settings in an attempt to estimate the extent of the problem. I would very much appreciate it if you would document, on the enclosed questionnaire, any incidents of aggression that you have witnessed or been personally involved in during your *clinical* work.

Following this initial data collection stage, all respondents are invited to a follow-up interview so that items of interest arising from an analysis of completed questionnaires can be discussed. All responses will be treated in strict confidence. Names of respondents will not be used in analysis of the data. Participation in this research is voluntary, you have the right to withdraw from the study at any time. Failure to respond will not affect you or your job position or career in any way.

All nurse educators working in the school of nursing are being canvassed for their assistance with this project.

I have read the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this investigation and understand that I may withdraw at any time.

I agree that research gathered for this study may be published provided that I cannot be identified as a participant.

This signed form must accompany any completed questionnaires.

Signature of participant ----------Date. ----------

Thank you in anticipation of your help.

Gerry Farrell
School of Nursing
University of Tasmania
Launceston Campus
Tel: (003) 243227

AGGRESSION AT WORK

Nurse Questionnaire

Please answer the questions below regarding a specific aggressive event you have witnessed or were personally involved in during your work as a *clinical* nurse. Event/s reported may range from serious to minor. Three questionnaires are enclosed, if you want to report on more incidents, blank questionnaires are available from me, alternatively you can photocopy one of the enclosed forms.

Aggressive incident which:
I witnessed; - please tick ✓ whichever applies.
was personally involved in.

1. Who was involved - please indicate the gender of those involved as well as their work/patient roles?

2. Where did the incident happen (to include name of setting, eg., A & E, and specific location, eg., corridor)?

3. When did the incident happen (to include year and time of day)?

4. What do you think led up to the incident?

5. What actually happened?

6. Why do you think the incident occurred?

7. How did the incident end?

8. What happened after the incident?

9. Please place an "x" on the line below that best represents your view of the seriousness of the incident. Very serious _____ Not at all serious

Further comments:

To help classify your responses please complete the following items.

10. Number of years as a qualified nurse.

11. Number of years as a nurse at time of incident.

12 Gender. Please circle whichever is appropriate: Female

Male

13 Age. Please circle the letter that represents your age band:

a). 21 - 30
b). 31 - 40
c). 41 - 50
d). 51 and above.

I can be contacted to arrange a time to discuss my experiences of aggression at work, please tick appropriate box. YES ☐ NO ☐

My contact telephone number is:

Name:

THANK YOU FOR YOUR HELP

Appendix 2: Aggression in the Clinical Setting (Four Items)

AGGRESSION IN THE CLINICAL SETTING

On the following scales please place an 'x' that best represents your view regarding the extent of aggression in the clinical setting

	Aggression extremely unlikely	Aggression extremely likely
a) Patient to staff		
b) Patient to patient		
c) Staff to patient		
d) Staff to staff		

THANK YOU FOR YOUR HELP

Appendix 3: Video Clip

All respondents saw the same scene, however, there were nine different introductions as to the nurses' grades/levels - making a total of nine "different" scenes with each being watched by 30 respondents. One group of respondents were told that they were watching an incident between two Level-1 nurses, another group were informed that the altercation was between a Level-1 nurse and a Level-2 nurse, and so on until all nine scenes were accounted for.

(A copy of the VHS videotape used in data collection is enclosed)

Appendix 4: Questionnaire for Phase 2

(Please note this questionnaire forms part of a larger investigation that the researcher is conducting, therefore not all of the items are reported on in this thesis)

Thank you for agreeing to take part in this project.

INSTRUCTIONS

People vary in what they regard as aggression and to help me appreciate the range of nurses' views please give a brief description of your most distressing aggressive episode at work.

.....

.....

.....

.....

Now please watch the video before answering the questionnaire items.

VIDEO SCENARIO

The video scenario that you are about to watch includes two nurses - April and June. April, a clinical nurse manager (level 3), is in an office next to the nurses' station on the ward. She is waiting to go off duty as her work shift has finished, however she needs to speak with June, also a clinical nurse manager (level 3). June arrives 15 minutes later.

After you have watched the video please turn the page and complete the questionnaire. Try to answer all the questions. Your responses will help in our understanding of this important topic. There are no right or wrong answers.

IN CONFIDENCE

This questionnaire to be completed after you have viewed the video scenario.

Please try and answer all the questions. It is your responses that will help increase our understanding of this important topic.

Q. 1. In your opinion, to what extent do you think each of the two nurses should be blamed for starting the incident?
Please circle the appropriate numbers below.

	Strongly disagree					Strongly agree
a) April, the clinical nurse manager who was waiting to go off duty, should be blamed.	1	2	3	4	5	6
b) June, the clinical nurse manager who arrived late, should be blamed.	1	2	3	4	5	6

Q. 2. In terms of its seriousness, how would you rate the incident?

Not at all serious					Very serious
1	2	3	4	5	6

Q. 3. Incidents such as that between April and June are to a large extent "part of the job". What is your opinion?

Strongly disagree					Strongly agree
1	2	3	4	5	6

Q. 4. According to my first feeling-reactions, I would willingly admit April and June to one or more of the classifications below. For each of the classification circle Y for "yes" or N for "no".

	A To be a close friend	B To work with on a team	C To work with on the same shift	D To work on an opposite shift to me	E To work on a differen ward to me	F To work in a different hospital to me	G To leave nursing
April (The clinical nurse manager who was waiting to go off duty).	Y N	Y N	Y N	Y N	Y N	Y N	Y N
June (The clinical nurse manager who arrived late).	Y N	Y N	Y N	Y N	Y N	Y N	Y N

Q. 5. Imagine for a moment that a week later April and June find themselves at work together, how likely is it that they will sort out their difficulties?

Not at all likely					Very likely
1	2	3	4	5	6

This section examines the nature and extent of aggression in the clinical setting

Q. 6. On the following scales please circle a number that best represents your view regarding the extent of aggression in the clinical setting (include incidents that involved yourself as well as those you witnessed).

	Aggression extremely unlikely					Aggression extremely likely	Not enough infor-mation to answer
a) patient to nurse	1	2	3	4	5	6	7
b) patient to patient	1	2	3	4	5	6	7
c) nurse to patient	1	2	3	4	5	6	7

	Aggression extremely unlikely					Aggression extremely likely	Not enough information to answer
d) nurse to nurse (all grades)	1	2	3	4	5	6	7
e) levels 1& 2 to clinical nurse managers (level 3)	1	2	3	4	5	6	7
f) clinical nurse managers to nurses junior to them (levels 1 & 2)	1	2	3	4	5	6	7
g) nurse managers (level 4s and above) to nurses junior to them	1	2	3	4	5	6	7
h) levels 1 - 3 to nurse managers (levels 4 and above)	1	2	3	4	5	6	7
i) non-nurse managers to nurses	1	2	3	4	5	6	7
j) nurses to non-nurse managers	1	2	3	4	5	6	7
k) patients' relatives to nurses	1	2	3	4	5	6	7
l) nurses to patients' relatives	1	2	3	4	5	6	7
m) patients or their relatives to nurses over the telephone	1	2	3	4	5	6	7
n) Nurses to patients or their relatives over the telephone	1	2	3	4	5	6	7
o) between the relatives of a patient	1	2	3	4	5	6	7
p) from doctors to nurses	1	2	3	4	5	6	7

5

	Aggression extremely unlikely					Aggression extremely likely	Not enough information to answer
q) from nurses to doctors	1	2	3	4	5	6	7
r) from other disciplines to nurses.	1	2	3	4	5	6	7
- Please specify the discipline/s involved.....							
s) from nurses to other disciplines	1	2	3	4	5	6	7
- Please specify the discipline/s involved.....							

Q. 7. Of all the types of aggression outlined on the previous pages (a - s) which <u>for you</u> is the most distressing to deal with? Circle the letter that applies:

a b c d e f g h i j k l m n o p q r s

This next sections asks about your current experience of aggression

Q. 8. On the scale below please circle the number that best represents the frequency of aggression, from whatever source, you currently experience in your clinical work situation.

None at all 1 2 3 4 5 Daily 6

If you circled No. 1. please go to question 14.

If you circled another number please continue with the next question.

Q. 9. If you circled 2 or above for the previous question please indicate the nature of the aggression you experience?

You may circle more than one number.

Nature of aggression:

	Infrequent					Frequent
Abusive language	1	2	3	4	5	6
Humiliation in front of others	1	2	3	4	5	6
Others spreading malicious rumours about you	1	2	3	4	5	6
Others refusing to speak to you	1	2	3	4	5	6
Others failing to speak up for you in your defence	1	2	3	4	5	6
Being refused help to enable you perform necessary tasks	1	2	3	4	5	6
Others refusing to move out of your way	1	2	3	4	5	6
Rudeness	1	2	3	4	5	6
Threats of disciplinary action	1	2	3	4	5	6
Threats of job loss	1	2	3	4	5	6
Others stealing credit for your work	1	2	3	4	5	6
Being denied access to opportunities	1	2	3	4	5	6
Being set up to fail	1	2	3	4	5	6
Excessive scrutiny of your work	1	2	3	4	5	6
Unjustified criticism of you as a person	1	2	3	4	5	6
Unjustified criticism of your work	1	2	3	4	5	6
Others telling lies about your work	1	2	3	4	5	6
Threats to your family/friends	1	2	3	4	5	6
Threats of physical assault	1	2	3	4	5	6
Damage to your property (eg., house, car, etc.)	1	2	3	4	5	6
Physical assault	1	2	3	4	5	6
Other	1	2	3	4	5	6

- please specify - .....

.....

Q. 10. Please indicate on the list below who you feel is typically responsible for the aggression you experience at work.

You may circle more than one number

1. nurse colleague/s
2. nurse manager/s
3. non-nurse manager/s
4. patient/s
5. patients' relatives
6. doctor/s
7. others - please specify

.....

Q. 11. What has been your reaction to aggression?

You may circle more than one number.

	Not at all					Very much
Loss of confidence	1	2	3	4	5	6
Anxiety	1	2	3	4	5	6
Depression	1	2	3	4	5	6
Sleep problems	1	2	3	4	5	6
Poor work performance	1	2	3	4	5	6
Self blame	1	2	3	4	5	6
Fear	1	2	3	4	5	6
Change in eating/drinking habits	1	2	3	4	5	6
Headaches	1	2	3	4	5	6
Irritability	1	2	3	4	5	6
Anger	1	2	3	4	5	6
Wanted to get even	1	2	3	4	5	6
Considered leaving nursing	1	2	3	4	5	6
Tried to forget about incident	1	2	3	4	5	6
No real effect	1	2	3	4	5	6
Helped me gain insight into my own behaviour	1	2	3	4	5	6
Other	1	2	3	4	5	6

- please specify .....

.....

Q.12. What action, if any, did you take or have you taken?

You may circle more than one number

Talked about situation with person concerned	1
Talked about situation with manager	2
Talked about situation with human resource department	3
Talked about situation with union/professional organisation	4
Talked about situation with colleagues	5
Talked about situation with a friend	6
Talked about situation with family member	7
Sought professional help	8

- please specify.....

Kept it to yourself	9
Other	10

- please specify.....

Q. 13. Did any of the above help? If so, which? .....

To judge the importance of workplace aggression for nurses the next question asks you to estimate how distressing workplace aggression is for you compared to other distressing aspects of your work.

Q. 14. Please complete the following sentence: "All things considered the most distressing aspect of my work is:

.....

..... "

If you cited aggression - from whatever source - as the most distressing aspect of your work please go to question 15.

If you wrote something different give that aspect of your work a score of 10. Now score the distress caused by aggression using a 0 - 9 point scale. For instance, a score of 5 would indicate that aggression at work was half as distressing as your most troublesome concern. A score of 9 would indicate that aggression was almost as distressing as your most troublesome concern.

Aggression at work rates a score of: .....

This section deals with co-worker relationships.

Q. 15. It has been suggested that in work relationships there are a number of rules expected of co-workers. All things considered, how well do the rules below apply to your co-workers? Circle the numbers that apply.

	Rarely					Always
1. Accept one's fair share of the work load	1	2	3	4	5	6
2. Respect others' privacy	1	2	3	4	5	6
3. Be co-operative with regard to the shared physical working conditions (eg., noise, space)	1	2	3	4	5	6
4. Be willing to help when requested	1	2	3	4	5	6
5. Keep confidences	1	2	3	4	5	6
6. Work co-operatively despite feelings of dislike	1	2	3	4	5	6
7. Don't denigrate in front of others	1	2	3	4	5	6
8. Address co-workers by name	1	2	3	4	5	6
9. Ask for help and advice when necessary	1	2	3	4	5	6
10 Look co-workers in the eye during conversations	1	2	3	4	5	6
11. Don't be over-inquisitive about each others' private lives	1	2	3	4	5	6
12. Repay debts, favours, and compliments no matter how small	1	2	3	4	5	6
13. Don't engage in sexual activity with the co-worker	1	2	3	4	5	6
14. Stand up for the co-worker in her/his absence	1	2	3	4	5	6
15. Don't criticise the co-worker publicly	1	2	3	4	5	6
16. Don't gang up on one another	1	2	3	4	5	6

Q. 16. What training have you had in aggression management?

None 1

Some 2 - please specify .....

.....

This section seeks to understand your usual way of coping with stress.

Q. 17. Read each statement and then circle the answer that indicates how you generally feel. There are no right or wrong answers. Do not spend too much time on any one statement, but give the answer that seems to describe how you generally feel.

	Almost Never	Some times	Often	Almost Always
1. I am quick tempered	1	2	3	4
2. I feel annoyed when I am not given recognition for doing good work	1	2	3	4
3. I have a fiery temper	1	2	3	4
4. I feel infuriated when I do a good job and get a poor evaluation	1	2	3	4
5. I am a hotheaded person	1	2	3	4
6. It makes me furious when I am criticized in front of others	1	2	3	4
7. I get angry when I'm slowed down by others' mistakes	1	2	3	4
8. I fly off the handle	1	2	3	4
9. When I get mad I say nasty things	1	2	3	4
10. When I get frustrated I feel like hitting someone	1	2	3	4

Q. 18. How bad is it? How good is it?

How good or bad would it be, in your opinion, if a nurse like yourself on your present ward did any of the following things. Please put a check (/) for each item in the appropriate column.

	1	2	3	4	5	6	7
How bad is it if you *How good is it if you*	Very bad	Fairly bad	Slightly bad	Slightly good	Fairly good	Very good	It would depend
a) Occasionally arrive late for work.							
b) Sometimes stay on duty after your shift has finished without overtime payment.							
c) Take special pride in completing tasks by set times.							
d) Forget to give a patient his medication on time.							
e) Let some patients remain untidy.							
f) Find that sometimes you have to leave some tasks for the on-coming shift to complete.							

Q. 19. This section asks about certain aspects of your health over the past few weeks and the way you feel about them.

Please answer all the questions simply by circling the answer which you think most nearly applies to you. Remember we want to know about present and recent complaints, not those that you had in the past. It is important that you try and answer all the questions.

Have you recently:

1. been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2. lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3. felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
4. felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
5. felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
6. felt that you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more more than usual
7. been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
8. been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
9. been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
10. been losing confidence in yourself?	Not at all	No more more than usual	Rather more than usual	Much more than usual
11. been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
12. been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual

To help classify your responses please answer the questions below.

Q. 20. How many years have you been in nursing work (include years spent in nurse training and education)?.....

Please circle whichever number applies for each of the following questions.

Q. 21. Professional qualifications.

Registered Nurse (RN)	Registered Psychiatric Nurse (RPN)	RN & RPN	Enrolled Nurse	Registered Midwife
1	2	3	4	5

Q. 22. Post-basic nursing qualifications (eg Grad Dip) Yes 1 NO 2

If "Yes" please give title/s of qualification/s

.....

Q. 23. Work
Current Grade/level: 1 2 3 4

Currently working in:

Accident and Emergency dept.	1
Cardiac unit	2
Intensive care unit	3
Medical ward	4
Midwifery unit	5
Out patient dept.	6
Children's ward	7
Psychiatric in-pt ward	8
Rehabilitation - psychiatric	10
Rehabilitation - general	11
Surgical ward	12
Theatre	13
X- ray dept.	14
Other (please specify)	15

Q. 24. Do you work in the 1 private or the 2 public sector?

Q. 25. Are you working: Full time 1 Part time 2 Casual/on call 3?

Q. 26. Are you on contract? No 1 Yes 2

Q. 27. Are you predominantly on 1 day shift or 2 night shift ?

Q. 28. "Considering everything, I am satisfied with my job at the present time". How strongly do you agree with this statement?

Strongly disagree					Strongly agree
1	2	3	4	5	6

Q. 29. Please indicate your age in years .....

Q. 30. Your sex: 1 Female 2 Male

Q. 31. Your marital status.

Single	1
Defacto relationship	2
Married for first time	3
Remarried	4
Separated	5
Divorced	6
Widowed	7

PLEASE READ

As a follow-up to this questionnaire I would like to speak with participants about their experiences of aggression in the clinical setting. If you would like to participate please indicate your agreement on one of the "Agreement to be Interviewed Forms" on the table in front of you and place the completed form in the appropriate box. This way I will not know who has agreed to be interviewed from the information supplied in the questionnaires. Of course, there is no obligation to a follow-up interview, but it would help me understand the issues better as well as provide an opportunity for you to talk about the things that you see as important.

Please leave your completed questionnaire in the box provided.

THANK YOU VERY MUCH FOR YOUR HELP

Appendix 5: Agreement to Participate Form

Aggression in the Clinical Setting

This project seeks to understand the nature and extent of aggression faced by nurses at work. By obtaining the views of individual nurses we will be in a better position to say just what the important issues are for those in practice. You are asked to watch a short video clip of an interaction between two nurses and then complete a questionnaire. All your responses will be anonymous. I do not need to know your name and once you have completed the questionnaire I will not be able to say who completed which questionnaire. Please note that you do not have to take part in this project. Refusal will not affect your job in any way. If you agree to take part you do not have to complete all the questions and you can withdraw from the study at any time without giving a reason for your decision to withdraw.

Agreement to Participate in the Research Project.
The conditions of this project have been satisfactorily explained to me.

Signed.....

Now please tear off this front sheet and place it in the box marked Agreement to Participate. I need to retain all of these forms until completion of the project after which this box and its contents will be destroyed.

Mr Gerry Farrell
Senior Lecturer
Tasmanian School of Nursing
1995

Appendix 6: Study Outline for Directors of Nursing

Proposed Study Title: The Nature and Extent of Aggression in Nursing.

Introduction:

Most of the studies on aggression in nursing and in other health-related disciplines have concentrated on determining its incidence. Target areas for study have included accident and emergency departments, psychiatric hospitals and community settings. But it is difficult to compare one study with another due to uncertainty surrounding the definition of aggression. As well, there are methodological difficulties. Nevertheless, such studies have spawned prolific rhetoric regarding what needs to be done to protect nurses from the perceived threat of a rising tide of aggression by patients towards nurses. While it is reasonable to expect that all nurses are adequately prepared to deal with aggressive encounters from patients we should proceed with caution here. True, nurses suffer physical harm and emotional upset following incidents of aggression from their clients, true also is the fact that nurses are one of the most likely targets of patients' assaults; what is not so readily apparent is what nurses mean by the term "aggression". If we are to train nurses in the successful management of aggression, it is paramount we have a thorough understanding of what is meant by the term within a nursing context. Otherwise, we are in danger of providing courses that do not equate with what the average nurse sees as "aggressive". To date, there appear to be no studies reported which empirically determine how nurses view the concept. Most studies either take the concept as a given - aggression is aggression, or, in the main, rely on ideas from theorists outside nursing. Even social scientists' ideas on lay views of aggression have rarely

been subject to empirical validation away from the laboratory or outside theorists' own minds.

As well as reporting what nurses understand by aggression, we also need to distinguish between aggression from patients and aggression from others. The notion of horizontal violence has crept into nursing discourses on the nature of nurses' work. But just how concerned are nurses about this aspect of aggression? To date, there appears to be no empirical studies on this issue either. Answers to this question would also be important in determining what areas to target if we are to offer a comprehensive education and training in aggression management for nurses.

This study attempts to (a) offer an understanding of "aggression" that is in keeping with nurses' use of the term and (b) establish from whom nurses see aggression as being most problematic.

Methodology:

Phase 1. The problem posed for nurse researchers is to develop an understanding of what is meant by "aggression" that is in keeping with the "average" nurse's use of the term. It is important to move away from the mainly sterile descriptions offered in many sociopsychological and nursing texts and to develop an understanding that is based on real incidents. As a first step, nurses will be asked about their experience of on the job aggression. Such a descriptive account of nurses' collective wisdom would be a major step forward in determining some of the parameters regarding what constitutes an aggressive act.

Phase 2. To test just how salient given descriptions are for nurses and to determine the influence of contextual factors a follow-up confirmatory study is proposed. For this study, a larger sample of nurses will be asked to rate incidents of aggression in terms of, for instance, the seriousness of the event, and who is to blame for the incident. At this stage, further analysis in terms of the raters' characteristics as they influence perception of events can be considered. In this way, we can begin to bring order to this diverse concept, and see to what extent one can talk about underlying/unifying concepts/crucial dimensions or models involved when thinking about aggression within a nursing context.

For Phase 2. I require a sample size of at least 270 nurses or more to view a short video clip of an aggressive encounter. After watching the video the nurses will be asked to answer a short questionnaire.

Gerry Farrell
Senior Lecturer
Tasmanian School of Nursing
April 1995

Appendix 7: Letter to Director of Medical services

UNIVERSITY OF TASMANIA

Tasmanian School of Nursing
PO Box 1214
Launceston
Tasmania 7250
Australia

23rd February 1995

Dr [redacted]
Director of Medical Services
[redacted]

Dear Dr [redacted]

RE: PERMISSION TO CONDUCT A RESEARCH PROJECT WITH NURSING STAFF.

I am conducting a study into the nature and extent of aggression within a clinical nursing context for which I have ethical approval from the University of Tasmania. Thus far, I have interviewed nursing staff from both university and hospital settings. I am now about to embark on phase two of the study and for this I need the co-operation of nursing staff at the [redacted] Hospital - please refer to enclosed study outline which I gave to [redacted] Director of Nursing. While [redacted], following discussion with the relevant nursing programme directors, is happy for the project to proceed she suggested I write to you to inquire if I needed separate approval from the hospital research and ethics committee. Once, I have permission to proceed, [redacted] will write to the various wards to inform them of the project and the voluntary nature of staff participation.

I am happy to come and discuss the project with you should you require further information. I am normally on ward [redacted] Tuesday afternoons where I am involved in a project on patient satisfaction.

I look forward to hearing from you.

Yours sincerely

Gerald A Farrell
Senior Lecturer.

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